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Government
of South Australia

Report

of the

Auditor-General

Supplementary Report

for the

year ended 30 June 2015

Tabled in the House of Assembly and ordered to be published, 19 November 2015

Second Session, Fifty-Third Parliament

New Royal Adelaide Hospital report: November 2015

By authority: P. McMahon, Government Printer, South Australia

2015

General enquiries regarding this report should be directed to:

Auditor-General
Auditor-General's Department
Level 9
State Administration Centre
200 Victoria Square
Adelaide SA 5000

Copies may be obtained from:
Service SA
Government Legislation Outlet
Ground Floor
108 North Terrace
Adelaide SA 5000

Website: www.audit.sa.gov.au

ISSN 0815-9157

Government of South Australia
Auditor-General's Department

Level 9
State Administration Centre
200 Victoria Square
Adelaide SA 5000
DX 56208
Victoria Square
Tel +618 8226 9640
Fax +618 8226 9688
ABN 53 327 061 410
audgensa@audit.sa.gov.au
www.audit.sa.gov.au

18 November 2015

The Hon R P Wortley MLC
President
Legislative Council
Parliament House
ADELAIDE SA 5000

The Hon M J Atkinson MP
Speaker
House of Assembly
Parliament House
ADELAIDE SA 5000

Dear President and Speaker

Report of the Auditor-General: Supplementary Report for the year ended 30 June 2015: New Royal Adelaide Hospital report: November 2015

Pursuant to the provisions of the *Public Finance and Audit Act 1987*, I present to each of you a copy of my Supplementary Report for the year ended 30 June 2015 'New Royal Adelaide Hospital report: November 2015'.

Content of the Report

Part A of the Auditor-General's Annual Report for the year ended 30 June 2015 referred to audit work on the new Royal Adelaide Hospital that would be subject to Supplementary reporting to Parliament. This report provides detailed commentary and audit observations on aspects of the review of the new Royal Adelaide Hospital project.

Acknowledgements

The audit team for this report was Andrew Corrigan and Philip Rossi.

I also express my appreciation for the cooperation and assistance provided by the staff of the Department for Health and Ageing and the Department of Planning, Transport and Infrastructure during the course of the audit.

Yours sincerely

Andrew Richardson
Auditor-General

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New Royal Adelaide Hospital report

1. Executive summary

1.1 Introduction

The new Royal Adelaide Hospital (new RAH) is the largest social infrastructure project ever undertaken by the State. The new RAH is to be built, maintained, financed and provided with non-medical services and equipment using a Public Private Partnership (PPP) arrangement. A Project Agreement covering 35 years has been entered into between the State and the preferred PPP proponent, SA Health Partnership Pty Ltd (Project Co).

The total value of the arrangement at contractual close in June 2011 provided for a capital cost for design and construction by Project Co of $1.85 billion (nominal). This excluded the Department for Health and Ageing's (SA Health's) State funded works budget of $244.7 million (nominal) towards the overall hospital development and consists of those elements to be delivered and financed by the State, including core clinical equipment and precinct works.

The features of the new RAH include:

- providing 800 beds, comprising 700 multi-day beds and 100 same-day beds
- standardised single inpatient rooms with individual ensuites
- 40 technical suites (operating theatres, intervention suites and procedural rooms)
- the use of leading technology to ensure that supplies are easily and efficiently transported throughout the hospital using automated guided vehicles
- biomedical equipment and other clinical equipment which are electronically tagged.

The Project Agreement documents the contractual obligations of both the State and Project Co.

1.2 Audit approach and scope

The new RAH project is a generational project in terms of its scale, complexity, cost, the resources allocated and its importance in providing enhanced and sustainable health care services and outcomes to the public of South Australia. The new RAH forms part of a reform program being developed to ensure the State has a responsive and sustainable health system for the future.

Establishing and maintaining robust governance arrangements and effective management oversight processes is crucial to the successful delivery of this complex project. In particular, it is essential that effective and efficient management and decision-making systems and processes are in place and regularly reviewed and revised throughout the project lifecycle.

Our review of aspects of the project has been ongoing[1] and will continue throughout its lifecycle. Our review is progressing in phases reflecting the ongoing nature of the project, and the key project lifecycle stages and milestones.

This phase of our review focused on the project status and reviewing the arrangements established by the State to enable the project to be delivered on time, within budget and with the intended benefits realised. We gave specific focus to project governance, management and reporting arrangements including:

- project governance and organisational structure
- assurance processes
- business planning
- risk management
- budgetary and financial management
- contract administration and management
- procurement.

There were a number of other important management arrangements and initiatives impacting on the project, such as transition planning, operational commissioning, health reform initiatives and the readiness strategy for the project that were not subject to detailed assessment as part of this phase of our review. Aspects of these arrangements and initiatives will be considered in subsequent audits.

Further, it is important to note that our observations, findings and conclusions reflect our understanding, discussions, enquiries, testing procedures and evidence obtained at a point in time. SA Health and the new RAH Program are continually reviewing and revising systems, processes and practices to address emerging issues. These issues have been highlighted from governance committee decisions and action items, outcomes from reviews by independent consultants and our ongoing review process. Consequently, where appropriate and relevant, our findings and recommendations will be subject to follow-up in subsequent review phases.

1.3 Project delivery status

Design and construction works continue to be progressed by the subcontracted builder. At the time of this Report most design work has been completed. Construction works are well advanced with packages of works being progressively completed and commissioned. Further, external State funded works facilitated by the Department of Planning, Transport and Infrastructure (DPTI) continue to be progressed.

Independent advice obtained by SA Health during 2014-15 indicated that works were behind schedule and the original contractual Commercial Acceptance date (18 April 2016) was likely to be exceeded.

The project was also at risk of delay from completing components of clinical equipment, information and communications technology (ICT) and requests for facility modifications. The effect of Project Co's claims for pre-existing not known contamination claims was also unresolved through 2014-15.

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[1] Refer to the Auditor-General's Annual Report for the year ended 30 June 2014, Part A, pages 30-34 and the Supplementary Reports for the years ended 30 June 2014 and 30 June 2015: 'Matters of specific audit comment: December 2014', 'Health ICT systems and the Camden Park distribution centre: June 2015' and 'Information and communications technology report: October 2015'.

In September 2015, the Minister for Health entered into a Deed of Settlement and Release (the Deed) with Project Co to resolve a number of these matters and agreed to extend the date of Commercial Acceptance by 76 days from 18 April 2016 to 3 July 2016.

1.4 Project budget and cost status

The total nominal construction budget for the new RAH project is $2.3 billion. The budget comprises the nominal construction cost by Project Co and State funded works (including transition costs). The components of the budget as at 30 June 2015[2] are:

	$'million
Construction cost by Project Co (nominal)	1 849.8
State funded works including transition activities (nominal)	417.4
Total	2 267.2

The status of the State funded works budget, including transition costs, as at 30 June 2015 is summarised in the table below.

	Current approved total program budget	Inception to date budget	Inception to date actual expenditure	Inception to date variation
	$'million	$'million	$'million	$'million
New RAH Program office	140.1	61.1	59.2	1.9
Capital works	234.9	56.6	54.7	1.9
Contingencies	42.4	2.0	-	2.0
Total budget	417.4	119.7	113.9	5.8

The above table shows that the inception to date budget for State funded works as at 30 June 2015 was underspent by $5.8 million. Our review noted, however, an unfunded Project Cost pressure of $9.6 million (excluding contingencies) and other expenditure risk items associated with delivering ICT services for the new RAH. This matter is further discussed in section 6.4.4. It is noted that the analysis above does not include potential budgetary and cost implications arising from the Deed executed between the Minister for Health and Project Co on 17 September 2015. We understand that at the time of this Report, SA Health was in the process of determining the full extent of the impact of the Deed on the State funded works budget.

1.5 Summary of key audit findings and observations

SA Health has implemented governance structures and arrangements to oversee the project. These arrangements have changed since the project commenced, primarily in response to advice received through a range of engaged assurance services. In particular, in response to the outcome of commissioned independent consultant reviews.

These reviews included providing assurance over the new RAH Program and reporting progress made by SA Health to address previous matters identified by the consultants as requiring improvement. Section 5 of this Report discusses the reviews performed by one such consultant.

[2] The budget information as at 30 June 2015 does not reflect the financial implications of the Deed executed between the Minister for Health and Project Co on 17 September 2015.

Our review identified a number of areas relating to program governance, assurance, management and reporting systems and processes that required improvement. The findings included matters that are significant to effectively managing project risks. In the course of the review, we noted the new RAH Program team progressively implemented a number of significant changes in processes and practices relating to the matters raised. These changes included revising assurance arrangements for the program, implementing a Project Contingency management framework, revising reporting on the status of clinical equipment procurements, and enhanced risk, budgetary and financial management reporting to the new RAH Steering Committee (the Committee).

Our findings were formally reported to SA Health in September 2015 and SA Health provided a detailed response to the matters raised, advising actions already taken or proposed. Details of the actions taken or proposed by SA Health are included in section 6. Further, at the time of this Report, SA Health advised that the majority of the recommendations had either been implemented or remediation was well advanced. These developments and proposed actions will be subject to further detailed assessment during our next review phase.

Details of our audit findings, risks and recommendations and SA Health's responses to the matters raised are included in section 6.

A summary of our key findings as at 30 June 2015 is provided below.

1.5.1 Project governance, assurance and reporting arrangements

- An independent consultant's April 2015 review followed up previous recommendations and focused on: governance, resources and PPP relationships; operational commissioning; procurement and the ICT program. It found significant progress or reasonable progress was made for most of the previous recommendations. There were also, however, areas where limited progress was made (refer section 5.1.4).

- There was a need to improve the assurance framework to provide the project's key governance committee with independent assurance on the program and progress achieved.

- SA Health had not completed an updated business case for the project and had yet to develop a formal robust process to monitor progress against the business plan.

- Whole-of-life costs for clinical equipment were not reported, and therefore were not monitored by the governance committees established to oversee the project.

- There was scope to improve reporting by the Project Director to SA Health.

1.5.2 Budgetary and financial management

- There was a need to improve budget and finance reports provided to the Committee, including providing project inception to date actual expenditure, explanations for significant variances between actual and budget/forecast expenditure and documenting how modifications were to be funded.

- Not all forecasts were adequately documented as they were not derived from actual expenditure to date, actual and expected commitments, known cost pressures and estimates of amounts still required to be spent to complete outstanding tasks required to deliver the project.

- Project contingency information provided to the Committee was insufficient to enable effective oversight and there was a lack of policy guidance for the allocation of contingencies and the required approval process.

- The budget for the new RAH ICT Program was subject to cost pressure and SA Health was in the process of, reviewing the budget and scope of ICT works, with the assistance of specialist ICT advisors.

- The potential funding shortfall and resulting cost pressure relating to ICT works was not reported to the Committee on a timely basis.

- There was scope to improve documentation to support the October 2014 funding request presented to Cabinet.

1.5.3 Risk management

- Risk information provided to the Committee required improvement to give a better understanding of the nature, consequences and status of strategic risks and strategies implemented to mitigate them.

- Process improvements were needed for approving key changes to risk information, highlighting changes to the Committee and ensuring consistency in the information recorded in supporting risk registers.

1.5.4 Contract administration and management

- There was a lack of a contract management framework and contract management plans for the clinical equipment procurement program.

- SA Health was in the process of reviewing the status of professional services contracts, including identifying the quantum, value and status of contracts for the provision of ICT services.

- There was scope to enhance contract management practices by documenting which officer had responsibility for ensuring compliance with specific clauses of the PPP Project Agreement and by providing regular reporting on the status of compliance.

1.5.5 Procurement

- For a number of procurement bundles the scope, timing and cost of project modifications were not agreed with Project Co and were considered an extreme risk. We understand these risks have now been crystallised and settled with Project Co following the State reaching a commercial settlement in September 2015.

- Reporting to the State Procurement Board on the status of the clinical equipment procurement program could be improved in terms of the frequency and content provided.

- There was a lack of effective reporting provided to the Committee regarding progress made in installing clinical equipment bundles against the time frames agreed to in the Master Work's Program.
- The agreement for probity assurance services for the clinical equipment program did not provide sufficient details regarding the nature and extent of services provided, the key deliverables and reporting requirements.
- The information provided to the Committee did not effectively report the status and key risks associated with the procurement and installation process in terms of the State meeting the time frames specified in the Project Agreement.

1.5.6 ICT functional, procurement and contractual dependencies

- The new RAH ICT Program was in the process of working with the enterprise ICT programs to identify detailed plans. These plans were at differing levels of maturity and completeness.
- There was a need to develop and implement a strategic acquisition plan to ensure a consistent approach to procuring the ICT services, enhance transparency and help to ensure the efficient and effective use of resources.
- There were a number of areas where contract management arrangements for new RAH ICT procurements required improvement.

1.5.7 Other key observations

Since contractual close in June 2011, the State funded works budget of $244.7 million has increased to $417.3 million at 30 June 2015. The majority of this increase relates to costs associated with the transition of services from the existing RAH to the new facility and increases to the ICT budget.

During 2014-15 delay risks for the State were emerging from modifications to the facility and completing its responsibilities for clinical equipment and ICT systems. Although SA Health was working through strategies to meet contract dates, a range of contingency actions were required due to the emerging risks. The State's monitoring through an independent review of the project had also concluded that Project Co was unlikely to deliver the project until the second half of 2016.

Under the Deed, the State agreed to pay Project Co $68.6 million in exchange for Project Co releasing the State from claims detailed in the Deed. This amount included:

- $20 million for the remediation of not known pre-existing contamination (includes the builder's direct and prolongation costs), which was a risk the State had retained in the contractual arrangements
- $10 million for clinical equipment modifications (includes the builder's direct and prolongation costs)
- $36.5 million to fund scheduled debt and equity payments and Project Co prolongation costs for 38 of the 76 days of the overall delay to Commercial Acceptance, which is based on the State and Project Co accepting sharing the finance delay costs and prolongation costs equally

- $2.1 million (net of credits owed to the State) for the settlement of other specific modifications and matters.[3]

Under the Deed, Project Co will:

- release the State from any further claims associated with remediation activities undertaken prior to December 2012 and clinical equipment modifications
- undertake the clinical equipment modifications prior to Technical Completion
- release the State from any other claims associated with the 76 days extension to Technical Completion and Commercial Acceptance
- pay its 50% share of finance delay costs (which would otherwise have been funded by the State as part of the service fee if Commercial Acceptance was achieved in April 2016 as planned).

Details of the Deed are further discussed in sections 2.3.8 and 2.3.9.

The total impact on the State budget from the Deed, approved by Cabinet, was a deterioration in net lending by 2016-17 of $34.3 million. This amount reflected the estimated impact of:

- the settlement payment (remediation and modification settlement amounts, the net effect of sharing the finance costs and prolongation costs)
- estimated additional operating costs (after allocating existing contingency funding) resulting from the negotiated delays in Commercial Acceptance and deferring the hospital opening, over and above the settlement payment amounting to $23.8 million.

The Date for Technical Completion for the project is now 4 April 2016 and the Date for Commercial Acceptance is 3 July 2016. The Deed was a negotiated agreement.

We understand that the Deed executed between the Minister for Health and Project Co on 17 September 2015, may address a number of the matters discussed in this Report. For instance, we understand that by executing the Deed, various risks related to project modifications and extension of time implications were crystallised and settled with Project Co.

The State and Project Co have agreed to a cooperative approach that ensures there is no further impact on the revised dates for Technical Completion and Commercial Acceptance and an agreed pricing methodology for future specified modifications.

As a result of the delay to the date for Commercial Acceptance, the Government announced a delay to the opening of the new RAH. It is now expected to open by November 2016. At the time of this Report, SA Health was addressing the implications of the delayed dates. The project continues to experience significant risks and challenges that require effective management.

[3] This is a net figure as it includes $0.6 million reduction in facilities management and lifecycle costs that have been credited to the State.

The full implications of the specific clauses contained in the Deed on the project will be considered in the next phase of our review.

1.6 Key challenges

The new RAH project has significant complexities and risks ahead as construction is completed, facility testing is performed and transition planning advances to the new target of November 2016. These are all subject to oversight by SA Health and the governance committees established to monitor the project. The following commentary provides a summary of some of the key challenges requiring ongoing focus and management attention:

- reviewing the impact, including previous risk assessments, of extending the key contractual completion dates by 76 days and deferring the opening of the hospital
- developing detailed operational planning and completing service delivery plans
- completing a refreshed business case for the new RAH, including determining and incorporating the impact of the Transforming Health reforms in the business case and underlying model of care and staffing levels for the new RAH
- addressing identified risks associated with implementing enterprise ICT systems, including meeting functionality, implementing deadlines, meeting budget targets and completing contingency systems and arrangements (refer to Auditor-General's Supplementary Reports previously referenced in footnote 1)
- settlement of claims by Project Co raised by the Facilities Management Subcontractor for modifications that were not settled by the Deed executed in September 2015
- addressing the outstanding matters and recommendations made by the independent consultant
- ensuring all work streams and programs are clear on their realistically achievable program of work, timelines, responsibilities, dependencies and interdependencies with other work streams or programs
- confirming there are clear communication and decision lines, authority delegations and accountabilities, and sufficient resourcing and budget authority and monitoring.

A number of these matters and recommendations are discussed in detail in section 7 of this Report.

1.7 Concluding comments

The objective of this audit review focused on the arrangements established to enable the project to be delivered on time, within budget and with the intended benefits realised.

Construction of the hospital is well progressed, though behind schedule. Since contractual close in June 2011, the budget for State funded works for the project has increased. This increase is primarily attributed to additional funding for transitioning from the existing hospital to the new hospital, which was previously not in scope, and an increase in the ICT budget. The total budget for State funded works including transition costs was $417 million.

The Commercial Acceptance date has extended by 76 days to 3 July 2016 and the hospital opening has been delayed to November 2016. The State is not able to use the hospital before the revised Date of Commercial Acceptance. The State is required to pay Project Co the quarterly service payments estimated at approximately $1 million per day from 3 July 2016 (ie the revised Date of Commercial Acceptance). We were advised that, once the scope of services required by the State for the period between Commercial Acceptance and the hospital opening is determined, the State intends to negotiate with Project Co a reduction in the quarterly service payments to reflect services which will not be required during this period.

The project business case, which sets out expected benefits from the project, is under review.

These changes are not unusual for a project of this size and complexity. It is, however, notable that the negotiated Deed was a moderated outcome compared to that initially implied by the strict conditions established by the project contractual arrangements, including the financial exposure for parties causing delays in completing and commissioning the hospital. We noted that until the negotiation of the Deed, those strict conditions significantly influenced the way SA Health managed some emerging risks. The negotiated outcome reflects that both parties had cause to reach agreement on longstanding disputed issues in order to focus on project completion. This outcome warrants considered reflection for future major contracts.

Throughout 2014-15, project governance arrangements continued to be enhanced as a range of issues and risks were identified. Notwithstanding this observation, we found that, at the time of our review, a number of important aspects of program governance, assurance, management and reporting systems and processes required improvement to effectively address key project risks. Further, a number of challenges require specific focus from SA Health to ensure successful delivery of the project's intended benefits.

The project is progressing through a critical phase of its lifecycle as the design, development and construction stage nears completion. Concurrently, the focus has moved to operational commissioning and the transition of services and infrastructure into the new hospital. From the date of this Report there are approximately four months to Technical Completion and seven months to Commercial Acceptance.

SA Health has demonstrated that it actively pursues and adjusts project governance arrangements to suit the complex requirements for the project. The vacated key positions of the Chief Executive, Central Adelaide Local Health Network (CALHN), and Program Director are now filled and the Committee has recently approved an enhanced assurance program to support other governance structures.

Whilst recognising these developments, agreeing to the commercial settlement reflected in the Deed conditions and the related payments, evidences that SA Health has accepted shared responsibility for project delays and financial consequences. This demonstrates that ultimately, it is how the myriad of complex tasks that comprise the project are delivered and interact that will determine the final timing and cost of moving into the new RAH. The governance arrangements must facilitate reliable and timely identification of emerging risks for timely response, action and decisions by responsible parties.

It is essential SA Health takes full advantage of the extension of time. SA Health must continue to ensure that it has all necessary equipment and systems in place at Technical

Completion so that State and Joint Operational Commissioning facility functionality testing and commissioning of State works can effectively and efficiently proceed and successfully meet that purpose. This period has contractual requirements to meet but critically, there are also expectations and requirements to meet a clearly articulated level of safe service for the hospital at opening.

Opening of the hospital is now approximately one year away under the revised timelines. SA Health will need to ensure that all processes necessary to successfully meet the revised dates are now settled at the earliest opportunity so that they effectively function to support appropriate actions and decision-making for this remaining period.

2 New Royal Adelaide Hospital Program background

2.1 Background

The new RAH is the largest social infrastructure project ever undertaken by the State with a total nominal budget of approximately $2.3 billion. This comprises a cost of $1.85 billion for design and construction costs by Project Co and State funded works of $417 million (at 30 June 2015).

The new RAH forms part of a reform program being developed to ensure the State has a responsive and sustainable health system for the future. The hospital will remain a major teaching hospital and will be located in close proximity to the South Australian Health and Medical Research Institute and University teaching and research facilities.

The new RAH replaces the existing RAH, which is South Australia's largest hospital currently providing 640 beds. The existing hospital was founded in 1840 and provides both tertiary and secondary health care services for South Australia.

The features of the new RAH include:

- providing 800 beds, comprising 700 multi-day beds and 100 same-day beds
- standardised single inpatient rooms with individual ensuites
- 40 technical suites (operating theatres, intervention suites and procedural rooms)
- the use of leading technology to ensure that supplies are easily and efficiently transported throughout the hospital using automated guided vehicles
- biomedical equipment and other clinical equipment which are electronically tagged.

The new RAH will provide an extensive range of complex medical, surgical, diagnostic, support services and a number of State-wide services.

The new RAH is being constructed on the former rail yard located at the corner of Port Road and North Terrace within the Adelaide CBD. The site comprises approximately 100 000 square metres, located in close proximity to the park lands and the River Torrens, and has three vehicle access points.

The new RAH project is substantively being delivered using a serviced infrastructure PPP model. Under this arrangement the private sector will design, construct, finance and provide a range of facilities management services over a defined period. The State will be responsible for providing clinical services and equipment for the hospital.

Under the Project Agreement the State is required to grant Project Co a licence (ie Operating Term Licence) to access the site for the period when the facility becomes operational (approximately 30 years) to the end of the term of the Project Agreement.

At the conclusion of the operating term, June 2046, Project Co is required to return the hospital and site back to the State in accordance with the Project Agreement.

Upon Commercial Acceptance, the State will recognise a lease asset and liability over the operating term of the Project Agreement. During this period the State is required to pay Project Co service payments for the construction, maintenance and operation of the infrastructure provided and financed by Project Co.

Construction of the facility commenced in late 2011 and it is currently expected to open by November 2016.

2.2 Drivers and expected benefits of the new Royal Adelaide Hospital

2.2.1 Reforms to the State public health system

In 2007 the State Government released South Australia's Health Care Plan 2007-2016 (SA's Health Care Plan) in response to the 2004 Generational Health Review. The review identified the need to change the way health services are delivered and the need to respond to the changing demographics of the State's population. SA's Health Care Plan addresses the key factors impacting the State's health system, including South Australia's ageing population, the increasing incidence of chronic disease, international health workforce shortages and ageing health system infrastructure. SA's Health Care Plan includes system-wide reform to reconfigure the State's public hospitals. By working smarter to make the State health system work better the aim is to provide the best possible services to the community into the future.

Replacing the existing RAH with the new RAH represents a key element of the State's reform process to address the health care needs of South Australians as detailed in SA's Health Care Plan.

2.2.2 Project objectives

The objectives of the new RAH project include:[4]

- leading cultural change through the SA Health system by creating an environment that encourages and supports staff to adopt new organisational values and systems of work, leading to a patient and outcome focused approach to care consistent with SA's Health Care Plan

[4] Source: Submission to the Legislative Council's Budget and Finance Committee, SA Health, October 2012.

- promoting innovation in health care delivery, education and training through a new hospital that:
  - embraces national and international design to encourage research and innovative practice, education and training
  - supports modern, technically advanced, highly safe and efficient service delivery
  - is appropriate for 2016 and for the next 70 years
- providing a hospital that is fit for the intended purpose through effective and efficient design that:
  - enables the provision of safe and effective care
  - provides the best possible environment for patients and staff
  - supports optimal use of technology
  - includes a post-disaster capability
- maximising efficient and effective delivery of the hospital
- providing value-for-money through best practice project management principals and the application of a sophisticated risk management approach
- embracing environmentally sustainable practices to minimise the new hospital's carbon footprint by:
  - minimising consumption of power and water
  - minimising the production of waste
  - maximising opportunities to recycle
  - minimising unnecessary community travel to obtain services.

2.2.3 Strategic drivers for the project

The strategic drivers of the project to address SA's Health Care Plan include:[5]

- safe patient care through standardisation, technology, best practice and efficiency
- enhanced access through multiple points of entry, effective way-finding and travel
- design features that create a healing and uplifting environment through natural light, colour, texture and form and external views
- embracing the key concept of a 'hospital in a park' in developing design themes
- landscape design solutions that create an opportunity for physical and emotional connections with nature
- integrated art outcomes that provide therapeutic, relaxation, functional benefits and cultural connections

[5] Source: Submission to the Legislative Council's Budget and Finance Committee, SA Health, October 2012.

- spaces that reflect diverse cultural, linguistic and spiritual needs of users, with specific focus on Aboriginal and Torres Strait Islander people
- design features that empower staff to provide high quality clinical care, allowing them to spend more time with the patient
- attracting and retaining staff by providing an enjoyable and welcoming working environment and amenities
- providing healthy staff work spaces where staff can interact, relax and work supported by superior infrastructure and a quality environment.

The expected outcome of strategic drivers is to deliver a functional, efficient, accessible and welcoming health care facility that is world class in terms of technology.

2.2.4 Project risks

The new RAH project is inherently a high risk project in terms of its scale, complexity, cost, the resources allocated and the importance of the project in terms of providing enhanced and sustainable health care services and outcomes to the public of South Australia.

The PPP model adopted to deliver the project and the underlying contractual arrangements have transferred significant risks associated with the project to Project Co, including risks relating to the design and construction of the hospital facility. However, significant risks were retained by the State as it is responsible for delivering key aspects of the project, including State funded works, clinical services (eg doctors, nurses and other health practitioners), clinical equipment, health ICT enterprise systems and other services. Some of these, particularly clinical equipment (which may require building design modification) and ICT, influence the construction schedule.

Accordingly, the Project Agreement establishes significant contractual obligations requiring the State to complete numerous tasks and contractual undertakings within specific time frames. Delays to the project deemed to have been attributed to the State expose it to significant financial exposures, adding to the overall cost of the project. Further, failure by the State to successfully coordinate and integrate the services it is required to provide with the facilities and operations to be delivered by Project Co, may result in the State not realising all the intended benefits from the project.

As was advised to Cabinet in October 2014, delivery of the model of care to the new RAH depends on a number of enterprise-wide systems being implemented and integrated. It was originally planned that EPAS and the Enterprise System for Medical Imaging (ESMI) were to be first rolled out at the existing RAH prior to the move to the new RAH, with the Enterprise Pathology Laboratory Information System (EPLIS) and iPharmacy required at the new RAH.[6]

[6] For further details regarding the scope and status of each ICT enterprise system refer to the Auditor-General's Supplementary Reports for the years ended 30 June 2014 and 30 June 2015: 'Matters of specific audit comment: December 2014', 'Health ICT systems and the Camden Park distribution centre: June 2015' and 'Information and communications technology report: October 2015'.

SA Health and the new RAH Program team were assigned responsibility to deliver the project. The new RAH Program has established a risk management process that is based on the SA Health Risk Management Framework and provides the basis of risk management policies and practices for the project. Consistent with the framework, we noted that SA Health regularly evaluated project risks and identified risk mitigation strategies to address the risks.

Our review of risk management processes for the project, however, identified a number of areas requiring improvement and action by management. In response, SA Health advised that it has implemented a number of measures to address matters raised. This included establishing a new RAH Integrated Risk and Program Committee. Details of the matters raised and SA Health's responses are detailed in section 6.3.

Project risks include, but are not limited to, the potential for:

- project delays
- cost pressures
- failure to meet the PPP contractual requirements and the incurring of financial exposures
- inadequate management of claims made against the State
- industrial disputes
- inadequate delivery of health enterprise ICT systems
- uncoordinated relocation to the new RAH site adversely affecting the safe transition of services and patients
- insufficient training of staff
- inadequate delivery of the intended benefits and outcomes
- inadequate delivery of a sustainable model of care
- misalignment with changes to the State's health care policy and strategic direction.

2.2.5 Contamination remediation contractual risk

The Auditor-General's Annual Report for the year ended 30 June 2014 commented on the status of an ongoing contractual risk relating to costs associated with the remediation of contamination identified at the new RAH site.

Under the contractual arrangement between Project Co and the State, the contamination risk associated with known pre-existing contamination was transferred to Project Co. However, there is a contractual risk sharing arrangement for not known pre-existing contamination whereby the State is required to reimburse 80% of remediation costs to Project Co. The State is also obliged to pay associated prolongation and finance delay costs for each day Project Co is delayed in resolving the not known pre-existing contamination.

Once a contamination claim is received the Project Director is required to undertake a review and determine whether Project Co has an entitlement under the Project Agreement. If the Project Director determines that Project Co is entitled to compensation under the Project Agreement, the Independent Certifier undertakes an assessment of consequential claims for extension of time and delay costs.

In 2012-13 Project Co submitted a claim made for not known contamination for direct costs and extension of time. The Project Director made a determination in relation to the direct costs for two of the components of this claim and both parties agreed an amount of approximately $457 000 (representing 50% of the costs claimed by Project Co) to settle the claim. The balance of the claim was submitted in late 2014, and the Project Director made a determination in December 2014.

Subsequent negotiations between Project Co and representatives of the State resulted in Project Co submitting a proposal for commercially settling the claims and other matters. After obtaining Cabinet approval, the Minister for Health and Project Co executed a Deed of Settlement and Release on 17 September 2015 to settle remediation contamination claims, certain project modifications and other disputed matters. A payment of $20 million was included in the total settlement for outstanding remediation claims (both direct and builders prolongation costs) that included the initially agreed $457 000. Details regarding the Deed are further discussed in section 2.3.8.

2.3 Implementation approach for the new Royal Adelaide Hospital

2.3.1 Overview of the project delivery arrangements

The new RAH project is being delivered substantially through a PPP arrangement. The Minister for Health entered into Project Agreement with Project Co to design, construct and finance the new hospital and provide a range of facilities management services.

Under the arrangements the State is responsible for completing State funded works and will continue to be responsible for providing clinical services and equipment for the hospital.

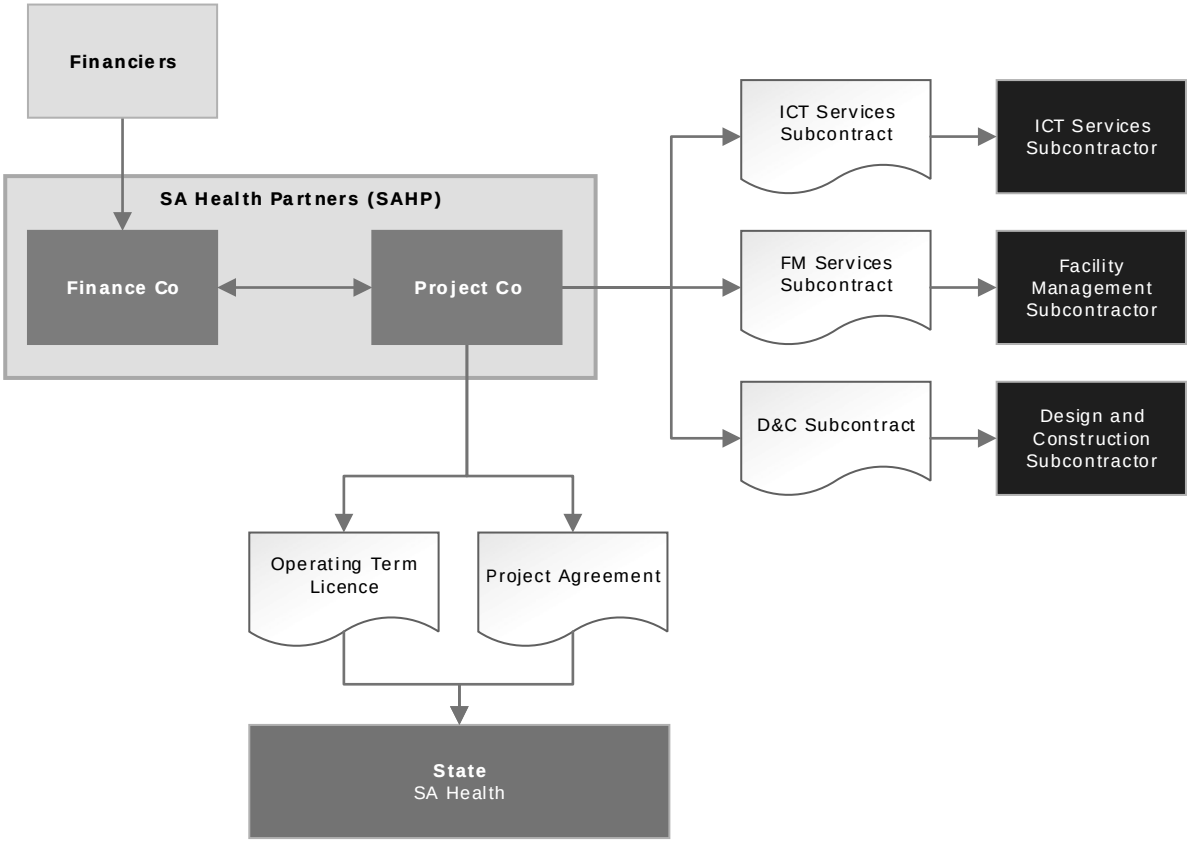
The term of the Project Agreement is 35 years, with a design and construction term of approximately five years and an operating term of approximately 30 years. The agreement was executed in May 2011, achieved financial close in June 2011 and is to conclude in June 2046.

The key parties to the arrangements include:

- the Minister for Health representing a body corporate acting for and on behalf of the State
- SA Health constituted as an administrative unit under the *Public Sector Act 2009* and nominated by the State as the organisation responsible for delivering the hospital services and functions
- Project Co representing the main entity contracted with the State to deliver the project
- financiers who have been arranged by Project Co to raise funds to pay for the construction of the hospital and other associated costs

- the Builder subcontracted by Project Co to design, construct and commission the new RAH
- other subcontractors engaged by Project Co, including the Facilities Management Subcontractor and the ICT Services Subcontractor.

The key parties and interrelationships relating to the PPP arrangements established to deliver the project are summarised in the following chart.



2.3.2 Responsibilities and services provided by Project Co

Under the Project Agreement, Project Co is required to build a facility that meets the purposes and specifications detailed in the State's output specifications. These activities include:

- designing, constructing and commissioning the site, hospital and designated commercial areas
- managing certain infrastructure enabling works
- procurement, installation, commissioning, maintenance and replacement of equipment and plant that is not provided by the State
- obtaining and complying with all development approvals.

Project Co is also responsible for providing a range of facilities management services during the operating term of the project. These services include:

- maintaining the hospital
- cleaning and general housekeeping

- porterage services and medical orderlies
- general waste management
- pest control
- security
- catering
- waste management
- bulk stores
- linen distribution
- internal distribution logistics.

Project Co is also responsible for designing and constructing the ICT network during the design and construct phase of the project, and providing ICT support and maintenance during the operating term of the project.

Further, under the Project Agreement, Project Co is required to procure debt and equity to finance the delivery of the project and take out a range of insurances for both the construction and operating phase of the project.

2.3.3 Project Co subcontractors

Project Co has entered into a number of subcontracts to deliver specific elements of the project. The major subcontracts are summarised in the following table.

Area of responsibility	Subcontractor	Services provided
Builder	HYLC Joint Venture incorporating Hansen Yuncken Pty Ltd and Leighton Contractors Pty Ltd	Design, construct, complete and commission the hospital
Facility Manager	Spotless Facility Services Pty Ltd	A broad range of facility management related services
ICT Services	Hewlett-Packard Pty Ltd	Provision of ICT services over the operating phase of the project. The subcontractor was also engaged by the Builder to design and construct the ICT network

2.3.4 Responsibilities and services provided by the State

In return for receiving services provided by Project Co, the State is required to pay service payments to Project Co during the operating phase of the project. Under the Project Agreement, the State is not required to make service payments for the hospital until the facility is successfully built to specification, commissioned, assessed to be fit for its intended purpose and operational services commence.

The service payments, which are paid quarterly partly in arrears, include finance charges (comprising principal, interest and equity distributions) and Project Co's fee for providing non-clinical services (such as facilities management services, ICT services and other services) as specified in the Project Agreement.

The nominal value of the service payments will vary over the term of the agreement (approximately 30 years) reflecting project lifecycle costs incurred by Project Co, such as payments for significant asset maintenance and replacement works.

The amount of the annual service payment the State is required to pay Project Co, inclusive of indexation, ranges between, $396 million p.a. and $478 million p.a. in the final year of the agreement (ie 2045-46).

The State is also responsible for:

- reviewing and endorsing design documentation and other material submitted by Project Co
- completing works outside the boundaries of the site, including road works, relocation of rail yards and other works
- providing clinical services
- installation, commissioning and testing ICT services and equipment to be provided by the State
- procuring, installing and commissioning, relocating and replacing equipment to be provided by the State (ie clinical equipment)
- managing the transition and relocation activities in accordance with the Project Agreement.

2.3.5 Key contractual terms, conditions and dates

The Project Agreement establishes strict contractual arrangements for project delivery and requires key tasks to be completed by both the State and Project Co within specified dates. The following commentary provides a summary of the key contractual requirements, terms, and dates.

Term	Description	Due date
Technical Completion	Defined as the stage of works where Technical Completion criteria have been satisfied, to the reasonable satisfaction of the Independent Certifier. Project Co must undertake a series of Technical Completion Tests that are detailed in the Technical Completion Plan. Should Project Co not be successful in demonstrating to the Independent Certifier and the Project Director that it has achieved Technical Completion, it must undertake a series of actions including resubmission of the Technical Completion Report.	Originally 18 January 2016 Revised to 4 April 2016
State Operational Commissioning	Defined as the operational commissioning to be conducted by the State during the Facility Transition Period. The Project Agreement provides a 90 day priority access period from the Date of Technical Completion (the Facility Transition Period). During this period the State is able to conduct various activities to test the functionality of the facility and commission the State works. The Transition Schedule and the State Operational Commissioning Plan, which is to be provided to Project Co, defines the State's activities during the Facility Transition Period.	Originally the 90 days to 18 April 2016 Revised to the 90 days to 3 July 2016

Term	Description	Due date
Joint Operational Commissioning	Defined as the operational commissioning to be conducted by Project Co during the Facility Transition Period. State Operational Commissioning and Joint Operational Commissioning activities may be undertaken concurrently providing that the State has priority access to undertake its State Operational Commissioning. The Commercial Acceptance Plan will set out activities to be undertaken by Project Co and the State as part of Joint Operational Commissioning. It also outlines how Project Co will respond to the State Operational Commissioning activities and coordinate activities to ensure achievement of Commercial Acceptance.	Originally the 90 days to 18 April 2016 Revised to the 90 days to 3 July 2016
Commercial Acceptance	Defined as the stage of works where the Commercial Acceptance criteria have been met to the reasonable satisfaction of the Project Director. The Commercial Acceptance Plan outlines the activities to be undertaken by Project Co to ensure achievement of Commercial Acceptance.	Originally 18 April 2016 Revised to 3 July 2016

2.3.6 Role of the Independent Certifier

The Project Agreement provides for the joint engagement (and sharing of costs) of an Independent Certifier until 12 months after the Date of Commercial Acceptance. The engagement includes progress reporting, completion requirements and change requests, such as extension of time requests. The Independent Certifier can be appointed as an independent expert as outlined in the Project Agreement for the purpose of accelerated dispute resolution.

In determining an entitlement to an extension of time request by Project Co, the Independent Certifier will consider certain matters, including relevant notices being submitted, the cause of the delay being an extension event, and the cause of the delay being beyond the reasonable control of the constructing party (ie Project Co). The Independent Certifier's determination can be disputed by either party through the dispute resolution process as set out in the Project Agreement.

Project Co had submitted claims for costs associated with the remediation of not known pre-existing contamination. On 17 September 2015 the Minister for Health and Project Co executed a Deed of Settlement and Release, which included the commercial settlement of outstanding remediation claims (both direct costs and delay costs).

At the time of this Report no determination had been made by the Independent Certifier regarding an extension of time, as the execution of the Deed negated the need to make such a determination.

2.3.7 Overview of obligations and financial implications relating to project delays

The PPP arrangements create strict contractual obligations and financial consequences for not completing the project within specified time frames.

The Project Agreement has transferred most of the risks relating to the design, construction and commissioning of the new hospital facility to Project Co. The Project Agreement requires the facility to be delivered for a fixed price on a fixed date (ie the original Date of Commercial Acceptance which was 18 April 2016). The design and construction of the facility is financed by Project Co's financiers (ie private debt and equity partners). Under the arrangements the financiers are entitled to receive repayments (approximately $1 million per day) from Project Co from the original Date of Commercial Acceptance. If the builder subcontracted by Project Co is delayed, Project Co can apply for liquidated damages from the builder and pay its financiers.

If there is a delay to the project that is attributable to the State prior to Commercial Acceptance, the State is required to pay Project Co approximately $1 million per day to cover finance costs (debt and equity) as well as prolongation costs. After Commercial Acceptance has been achieved, unless otherwise agreed, the full service payment (covering both finance and operating costs) is payable to Project Co, regardless of when the State elects to commence clinical operations.

2.3.8 Recent developments affecting the contractual arrangements

The Project Agreement originally provided for Technical Completion and Commercial Acceptance to be completed for the project by 18 January 2016 and 18 April 2016 respectively.

During 2014-15 the parties' public announcements consistently confirmed they were working to the contracted Technical Completion and Commercial Acceptance dates of 18 January 2016 and 18 April 2016 respectively. In the course of our audit, it was clear that SA Health was working to meet those dates. This was, however, requiring a range of contingency actions from original plans due to emerging risks.

In December 2014 the Minister for Health announced that an independent review of the project had concluded that the project delivery date had slipped to the second half of 2016.

Throughout 2014-15 Project Co's claim for not known contamination for direct costs remained unresolved and Project Co had not submitted a claim for a related extension of time. The State was managing emerging delay risks from modifications to the facility and delays in completing its responsibilities for clinical equipment and ICT systems (refer to Auditor-General's Supplementary Reports previously referenced in footnote 1).

The 2015-16 State Budget released on 18 June 2015 recognised the balance sheet impact of the new RAH in 2016-17, stating it reflected independent advice on expected Commercial Acceptance dates. It qualified that in the event that Commercial Acceptance occurred in 2015-16, the lease obligation would be reported in 2015-16.[7]

Following negotiations between Project Co and representatives of the State, in September 2015 Project Co proposed a commercial settlement. This was to resolve a number of the long outstanding issues relating to the project, including contamination remediation, project modifications and other disputed matters.

[7] 2015-16 Budget Statement, Budget Paper 3, page 8.

On 14 September 2015 Cabinet considered a recommendation that the Minister for Health accept Project Co's proposed Commercial Settlement of remediation, modifications and other disputed matters and execute a Deed of Settlement and Release under the new Royal Adelaide Hospital Project Agreement. Key issues that led to this recommendation are summarised as follows.

Project Co had submitted a formal claim for remediation of not known contamination in November 2014. The final costs (direct and delay) were not resolved. The new RAH Project Director had made two determinations for remediation compensation to Project Co. The most recent determination in August 2015 reduced the compensation (excluding delay costs) from $15.5 million to $14.6 million. There was perceived to be a significant risk of long-term disputation and costs through expert determination and arbitration.

SA Health required modifications to the facility arising from omissions in the State's design specifications and final selection of major clinical equipment which then required changes to completed rooms/areas, and from clinical requests for the up-to-date technology and equipment (noting the design briefs were prepared in 2008).

The recommended action to enter into the Deed aimed at resolving the uncertainties existing over the Date of Commercial Acceptance, remediation costs and time, and clinical equipment related modification costs and time.

SA Health also took the opportunity to negotiate a fixed agreed price for a number of known modifications that were not fully designed or priced by Project Co at the time and include other longstanding disputed items, such as the extent of shielding required for radiation bunkers. This was considered to allow all parties to focus on effective and cooperative relationships with a common goal of achieving completion in July 2016, with minimal defects and outstanding items and minimal contractual disputation over claims.

Cabinet was advised that:

- the terms of the settlement were jointly drafted by Project Co's legal advisers and the Crown Solicitor's Office
- the members of the Committee representing SA Health, CALHN, DPTI, the Department of Treasury and Finance and the Crown Solicitor's Office were fully briefed and had endorsed the negotiation of the proposal and recommendation.

The Department of Treasury and Finance was consulted on the budget impact of the proposal and provided a costing comment.

Cabinet approved to accept the commercial settlement proposed by Project Co and approved the Minister for Health to execute the Deed on behalf of the State. Consistent with the approval, on 17 September 2015 the Minister for Health formally accepted Project Co's proposed commercial settlement and both parties executed the Deed.

The key elements of the settlement as reflected in the Deed included:

- the State unilaterally extending the Date for Technical Completion by 76 days from 18 January 2016 to 4 April 2016 and the Date for Commercial Acceptance by 76 days from 18 April 2016 to 3 July 2016

- Project Co releasing the State from all claims (including extension of time/delay costs) in relation to:
    - remediation of non known pre-existing contamination activities before 31 December 2012
    - modifications required for State selected fixed clinical equipment
    - the extension of completion dates (ie Technical Completion and Commercial Acceptance)
    - other modifications and agreed matters
- the State agreeing to pay Project Co $68.6 million in exchange for Project Co releasing the State from claims detailed in the Deed comprising:
    - $30 million for direct costs including builder prolongation costs (for contamination remediation and modifications)
    - $36.5 million for delay costs
    - $2.1 million (net of credits owed to the State) for the settlement of other specific modifications and agreed matters
- Project Co paying a 50% share of agreed finance delay costs
- the State and Project Co agreeing to work cooperatively to implement any future modifications (which are specified in the Deed) that the State elects to undertake without impacting (where reasonably possible) the Date for Technical Completion and the Date for Commercial Acceptance. Further, Project Co must ensure the future modifications are priced on an open book basis.

The Deed explicitly specifies that the State acknowledges that the Deed does not apply to claims raised or to be raised by the Facility Management Subcontractor pursuant to the Facility Management Subcontract for its costs, which Project Co is entitled to under the Project Agreement for specific modifications.

In effect, we understand that this provision of the Deed does not release the State from claims for certain modifications relating to facilities management that Project Co would have been entitled to under the Project Agreement had the Deed not been entered into. In other words, Project Co and the State are still able to make claims for direct costs incurred by the Facility Management Subcontractor due to Project Co undertaking specific modification works.

Acceptance of the proposed settlement did not resolve all modifications under the Project Agreement, past or future. Some past modifications could not be agreed, and some known future modifications could not be included due to insufficient information being available.

These future modifications are to be administered in accordance with the Project Agreement, supported by commitments in the Deed which acknowledge that there are outstanding modifications and agreement to a cooperative approach that ensures there is no impact on the revised Dates for Technical Completion and Commercial Acceptance and an agreed pricing methodology.

At the time of this Report, we were advised the State was in the process of resolving matters relating to claims raised or to be raised by the Facility Management Subcontractor.

2.3.9 Implications of the revised contractual arrangements

The Deed was a negotiated agreement. Under this agreement the State agreed to pay $30 million of direct and prolongation costs. This comprised $20 million for the remediation of not known pre-existing contamination and $10 million for clinical equipment modifications.

The State will also pay $2.1 million (net of credits owed to the State) for the settlement of other specific modifications and agreed matters.

In addition, the State will also pay delay costs totalling $36.5 million in August 2016. The costs represent 50% of the finance costs payable to Project Co's financiers and Project Co's prolongation costs incurred during the 76 day extension of the Commercial Acceptance date. Project Co is required to pay the remaining 50% of finance costs payable to the financiers and absorb all other prolongation costs.

The finance costs mainly represent principal repayments, interest repayments and equity distributions. The other prolongation costs mainly include costs associated with the Independent Certifier, facility management delay costs and legal costs, Project Co management and other costs, ICT mobilisation costs and compensation for lost commercial area revenue.

The State is not able to use the hospital before the revised Date of Commercial Acceptance.

Following the extension of the Commercial Acceptance date from April 2016 to July 2016, the State decided to open the hospital by November 2016 to avoid the winter period and ensure a safe, seamless transition for patients and staff.

During this period the State is required to pay Project Co the quarterly service payments estimated at approximately $1 million per day from 3 July 2016 (ie the revised Date of Commercial Acceptance).

Further, Cabinet was advised that the net total impact on the State budget from the Deed was a deterioration in net lending by 2016-17 of $34.3 million.

The total impact on the State budget from the Deed, approved by Cabinet, was determined from adjustments to the existing budget estimates (that were based on meeting the original contracted project delivery dates) and any newly identified estimated costs associated with the delay and the Deed.

In addition to Cabinet approving to accept the commercial settlement proposed by Project Co, Cabinet approved associated budget adjustments for estimated additional operating costs resulting from the negotiated delays in Commercial Acceptance and the deferral of the hospital opening, over and above the settlement payment. The net total impact on the State budget from the Deed was based on the following.

	$'000	$'000
Estimated remediation and modification settlement cost		31 150
Prolongation costs		1 345
Additional operating costs:		
Continuation of the project office[(1)]	14 198	
Additional dual running costs	7 621	
Procurement holding costs	2 000	
Sub total		23 819
Less: Estimated reduction in finance costs		(21 996)
Total net lending budget impact		34 318

(1) This amount represents the estimated additional employee costs for the project of $25.063 million less funding which is to be allocated from existing project contingency established for project delays (ie $10.865 million).

The estimated reduction in finance costs of $22 million, mainly comprising reduced service payments, reflects costs previously budgeted to be incurred as part of the quarterly service fee based on the original Commercial Acceptance date. As indicated above, Project Co agreed to pay 50% of the finance costs payable to the financiers associated with the 76 day extension of the Commercial Acceptance date.

It is noted that the modification settlement amounts reflected in the Deed varied slightly from the estimate provided to Cabinet as the settlement and execution of the Deed occurred after the advice provided to Cabinet.

We understand that at the time of this Report, SA Health was in the process of determining the full extent of the impact of the negotiated delays in Commercial Acceptance and the deferral of the hospital opening, This may include, for example, revisions of anticipated costs associated with any amendments to ICT enterprise system implementation plans.

We were advised that, once the scope of services required by the State for the period between Commercial Acceptance and the hospital opening is determined, the State intends to negotiate with Project Co a reduction in the quarterly service payments to reflect services that will not be required during this period (ie catering, housekeeping, porterage and orderly services etc).

2.4 Project governance and organisational structure

2.4.1 Overview of governance arrangements

The new RAH is the largest and one of the most complex projects undertaken by the State. SA Health has implemented governance arrangements to oversee the project and to ensure the intended benefits are delivered to the South Australian health system. The arrangements are described in the following commentary.

The governance structure and arrangements for the project have undergone changes since the project commenced. Significant changes were made in response to the outcome of reviews undertaken by an independent consultant (ie Calcutta Group). The consultant, in its first review completed in June 2013, recommended the establishment of a governance framework that clarifies accountabilities and responsibilities of governance committees and key individuals. The consultant also recommended the establishment of a new RAH Program covering all the interrelated projects required to achieve successful operational commissioning of the new RAH.

In response, SA Health established a new RAH Program comprising nine work streams including an integrated project management office (ie Integrated Program Management

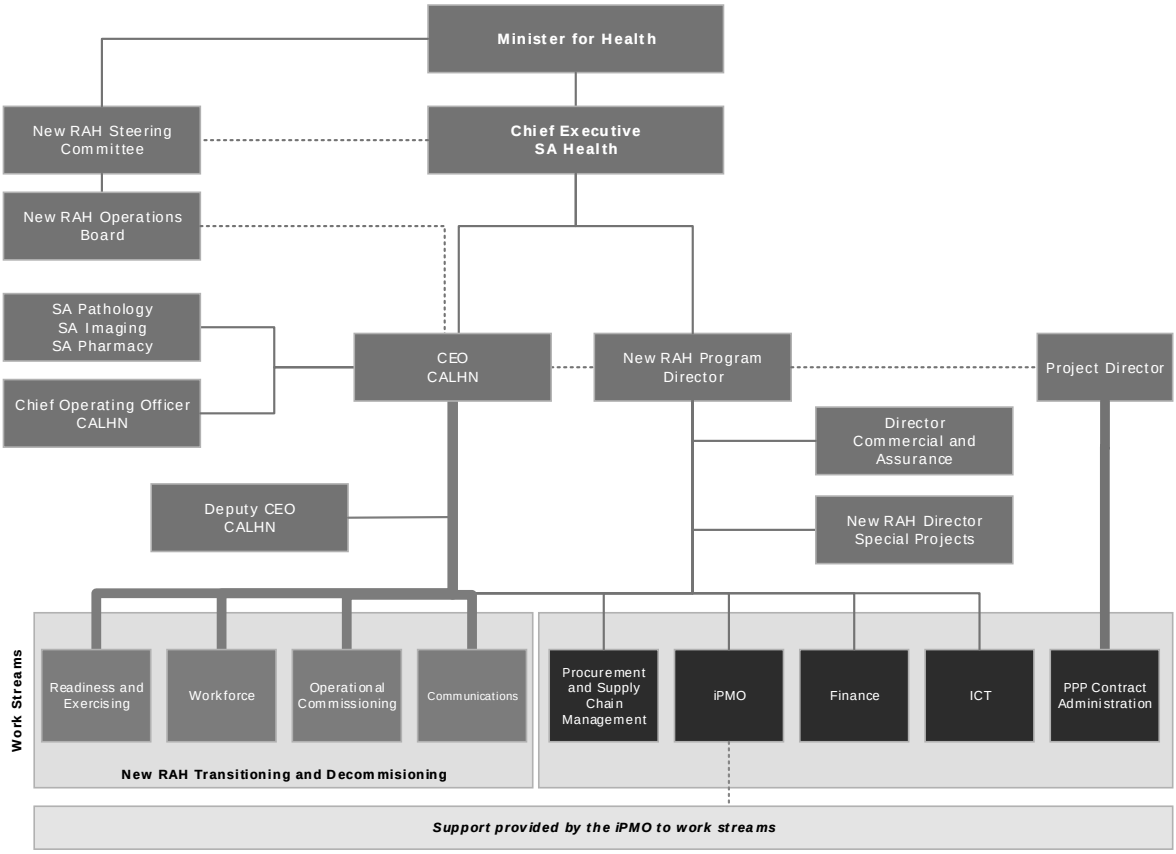
Office, iPMO). Further, it established a number of key governance committees including a revised steering committee (ie new RAH Steering Committee) and a new operations board (ie new RAH Operations Board). An interim Program Director was also appointed in January 2014 to provide an oversight role over the work streams.

Also, consistent with the recommendations made by the independent consultant in its first review, specific responsibilities associated with the administration of the Project Agreement were transferred from SA Health to DPTI. Under these arrangements:

- in October 2013 the Minister for Health appointed the Executive Director, Building Management, DPTI as the Project Director pursuant to the Project Agreement
- DPTI is responsible for managing the delivery of the infrastructure through the design and construction phases and subsequently the delivery of facilities management services in accordance with the Project Agreement[8]
- SA Health retains responsibility for aspects of specification/evaluation of requirements for the delivery of clinical services and the logistics of integrating services that will be transferred to the facility when the construction is completed.

2.4.2 Program organisational structure

The following chart summarises the governance arrangements established to deliver the new RAH project.



[8] At the time of this Report, SA Health advised that the arrangements for delivering contract management services during the operating period of the Project Agreement were under review.

2.4.3 Roles, responsibilities and reporting arrangements

The table below summarises the role, responsibilities and reporting arrangements of the parties providing a governance/oversight role over the project.

Party	Role, responsibility and reporting arrangements
New RAH Steering Committee	The Committee is the peak decision making body responsible for making decisions and recommendations to Government on matters having material impact on the project business case. Members are responsible for monitoring and providing strategic advice and direction for the project. The Committee generally executes actions by giving direction to the Chief Executive Officer, CALHN. The Committee is chaired by SA Health's Chief Executive with outcomes reported to the Minister for Health. The Committee commenced operating on 13 August 2013 and meets formally at least monthly. Membership of the Committee comprises: • SA Health, Chief Executive (Chair) • Senior Legal Counsel and Executive Solicitor • SA Health, Deputy Chief Executive – Finance and Corporate Services • SA Health, Deputy Chief Executive – Systems Performance and Service Delivery • Under Treasurer • DPTI, Chief Executive • Independent Member • CALHN, Chief Executive Officer • Independent Advisor.
New RAH Operations Board	The new RAH Operations Board is accountable to the Committee. The Board is responsible for developing an integrated program that ensures the successful delivery of the program of works for each work stream within the approved budget and time frames. The Board will generally execute any action through the new RAH Program Director or the Project Director. The Board is chaired by the Chief Executive Officer CALHN with the outcomes reported to the Committee. The Board commenced operating in November 2013 and meets at least monthly.

Party	Role, responsibility and reporting arrangements
	Membership of the Board comprises: • CALHN, Chief Executive Officer • CALHN, Deputy Chief Executive • CALHN, Chief Operating Officer • CALHN, Executive Director Business Reform • CALHN, Director Planning • Program Director • New RAH Director Special Projects • Project Director • Department of Treasury and Finance, Director Account Management • SA Health, Executive Director eHealth Systems and Chief Information Officer • SA Health, Group Executive Director SCSS.
Program Director	The Program Director is responsible for the day-to-day management and delivery of the new RAH Program. Further, the Program Director reports key aspects of the new RAH Program to the Committee through the Monthly Progress Reports. The current Program Director was appointed in May 2015 (effective 1 June 2015).
Project Director	The Project Agreement requires the State to appoint a Project Director responsible for administering the Project Agreement as the State's delegate. The Project Director is responsible for managing the delivery of the infrastructure through the design and construction phases and subsequently the delivery of facilities management services in accordance with the Project Agreement. The Project Director provides regular reports to project governance committees. The Project Director was appointed in October 2013.
Integrated Program Management Office	The role of the iPMO has been revised since it was established in January 2014. The iPMO provides monitoring and reporting on Program performance as well as providing project management support for Program works streams. The role of the iPMO was recently reviewed in July 2015 as part of a review of the Assurance Framework for the Program. This is further discussed in section 6.1.2.

2.4.4 Overview of Program work streams

Consistent with the recommendations made by the independent consultant (the Calcutta Group) the following work streams were established to help deliver the new RAH program:

- iPMO

- Communications
- Finance
- ICT
- Operational Commissioning
- PPP Contract Administration
- Procurement and Supply Chain
- Workforce
- Readiness and Exercising.

Each work stream has dedicated leaders who are accountable for delivering specific work packages in accordance with specific parameters in terms of time, scope of works and responsibilities, costs, quality and intended benefits. The following commentary provides a summary of the roles and responsibilities of each work stream.

Work stream	Role and responsibility
Integrated Program Management Office	The iPMO supports other program work streams through developing and maintaining systems, tools and processes including: • reporting • scheduling • risk and issue management • benefits management • quality management • project office management and secretariat. The role of the iPMO is further discussed in section 6.1.2.
Communications	The Communications work stream is responsible for developing a communications strategy and communications plan, and for executing communications activities for the new RAH project.
Finance	The Finance work stream is responsible for financial planning and analytics for the new RAH. This includes providing support to the iPMO, budget development and management, developing the new RAH Business Case, and developing and analysing operating costs of the new RAH post-Commercial Acceptance.
ICT	The ICT work stream is responsible for the State ICT requirements under the Project Agreement and for ensuring the ICT environment supports the model of care and the ICT needs of clinicians and patients.
Operational Commissioning	The Operational Commissioning work stream provides operational support to CALHN and State-wide services for transitioning, commissioning and relocation activities for the new RAH.
PPP Contract Administration	The PPP Contract Administration work stream provides expert contract administration services for the delivery of the new RAH project in accordance with the Project Agreement between the Minister for Health and Project Co.
Procurement and Supply Chain	The Procurement and Supply Chain work stream is responsible for procuring State funded works furniture, fittings and equipment (ie clinical equipment) and the delivery of a functional supply chain for the new RAH.

Work stream	Role and responsibility
Workforce	The Workforce work stream includes providing strategic and operational implementation of the workforce strategies for delivering the new RAH project. This includes providing workforce support for the other Program work streams, including change management, workforce profiling and planning, staff training and orientation of the delivery of the new RAH Program.
Readiness and Exercising	The Readiness and Exercising work stream is responsible for providing a structured approach and execution across all work streams for the testing and exercising activities for the new RAH Program.

3 Project delivery status

3.1 Description of project facilities

The location for the hospital comprises a site area of approximately 100 000 square metres located at the corner of Port Road and North Terrace, Adelaide. The design features include 10 levels accommodating single bed rooms, emergency service bays, technical suites (including operating theatres and procedural suites), outpatient areas (including consulting rooms and specialist rooms), and car and bicycle parking.

The main design features of the hospital are summarised in the table below.

Level	Feature
Level 1	Loading docks, kitchen, inpatient pharmacy, hospital infrastructure and service facilities, administrative support and accommodation, staff amenities and car parking.
Level 2	Emergency services, the Mental Health Unit, Radiotherapy Department, Nuclear Medicine, Hyperbaric Unit, Renal In-centre, patient bed rooms, clinical equipment, administrative support and accommodation and car parking.
Level 3	Main entry level including the main reception, retail and restaurant facilities, Outpatient Clinics, outpatient pharmacy, Pathology Unit, outpatient medical imaging, Phlebotomy, Cancer Day Unit, administrative support and accommodation, and bicycle and car parking.
Level 4	Intensive Care Unit, Technical Suites and recovery bays, patient bed rooms, ‘hot floor’ medical imaging, administrative support and accommodation.
Level 5	Patient bed rooms, inpatient medical imaging, teaching and training facilities, administrative support and accommodation, and a child care facility.
Level 6	Patient bed rooms and administrative support and accommodation.
Level 7	Patient bed rooms, helipad and administrative support and accommodation, and teaching and training facilities.
Level 8	Patient bed rooms, administration support and accommodation, and teaching and training facilities.
Level 9	Patient bed rooms, administrative support and accommodation.
Level 10	Air handling and heat rejection plant.

3.2 Status of works

The project is progressing through a critical phase of the project lifecycle as it transitions through the design and construction phase to operational commissioning and the transition of services from the existing hospital to the new hospital.

Design and construction works continue to be progressed by the subcontracted builder. At the time of this Report most design work had been completed. Construction works are well advanced with packages of works being progressively completed and commissioned. Further, external State funded works facilitated by DPTI continue to be progressed.

The independent consultant engaged to undertake an ongoing review of the achievability of the Master Works Program (MWP) has consistently reported that the contractual Commercial Acceptance date (ie 18 April 2016) was likely to be exceeded.

As mentioned previously, the Minister for Health agreed to unilaterally extend the Date of Technical Completion and the Date of Commercial Acceptance by 76 days from 18 January 2016 to 4 April 2016 and 18 April 2016 to 3 July 2016 respectively.

4 Project budget and expenditure to date

4.1 Total project budget for the new Royal Adelaide Hospital

4.1.1 Total construction and State funded works budget

As mentioned previously, the new RAH is being delivered through a combination of a PPP arrangement and works funded by the State.

The total budget for the new RAH project comprising the nominal construction cost by Project Co and State funded works (including transition costs) is approximately $2.3 billion. The components comprising the budget as at 30 June 2015[9] are:

	$'million
Construction cost by Project Co (nominal)	1 849.8
State funded works including transition activities (nominal)	417.4
Total	2 267.2

The construction cost by Project Co excludes financing costs and the costs of operating services provided by Project Co during the operating term. These costs, including State funded works, are further discussed under sections 4.1.3, 4.1.4 and 4.1.5.

4.1.2 Net present value of construction and operating services costs provided by Project Co

As reported in the Auditor-General's Annual Report for the year ended 30 June 2014, the estimated total risk adjusted value of the contractual arrangement at financial close (excluding

[9] The budget information as at 30 June 2015 does not reflect the financial implications of the Deed executed between the Minister for Health and Project Co on 17 September 2015.

State works) was $3160.6 million. This value represents the net present cost of financing the construction, maintenance and the provision of non-clinical services by Project Co over a 35 year period.

4.1.3 Summary of project budget approvals to 30 June 2015

The budget for the new RAH project has evolved since the original business case (the Outline Business Case) for the procurement of the facility using a PPP delivery model was approved by Cabinet in December 2007. The indicative nominal capital cost estimate for the project developed as part of the Outlined Business Case was $1677 million. This estimate was based on the information known at the time and reflected an initial cost model developed prior to site selection and investigation and cost design works being undertaken.

There have been a number of revisions to the nominal capital cost since Cabinet approved the business case in 2007 reflecting:

- changes made to the scope of works to meet the State's functional requirements
- additional State funded works including ICT works, utilities infrastructure works, clinical equipment, resources needed to mitigate project delays and transition costs.

In May 2011, Cabinet noted that the nominal estimated construction cost for the new RAH project was $2094.5 million comprising:

- Project Co's nominal construction cost of $1849.8 million
- State works costs of $244.7 million.

Cabinet also approved the Minister for Health executing the final Project Agreement and the Project Director signing the financial close documentation.

Consistent with the Cabinet approval, the PPP Project Agreement between Project Co and the State was executed in May 2011 and achieved financial close in June 2011. The scope of works, services and finance arrangements to be provided by the preferred PPP proponent (Project Co) for the project were finalised upon reaching financial close.

Details of revisions made to the total project budget (nominal) as approved by Cabinet since the PPP May 2011 approval is summarised in the table below.

	Approved budget at project agreement financial close May 2011	State funded electrical supply infrastructure works September 2012	State works transition funding October 2014	Removal of EPAS rollout funding from the State works budget May 2015
	$'million	$'million	$'million	$'million
PPP works	1 849.8	1 849.8	1 849.8	1 849.8
State funded works	244.7	248.1	424.6	417.4
Total	2 094.5	2 097.9	2 274.4	2 267.2

4.1.4 Budget for PPP construction costs

The contractual and financial close arrangements to build, operate and maintain and provide non-medical support services for the new RAH were concluded with Project Co in June 2011.

As previously mentioned, Project Co has subcontracted a builder (HYLC Joint Venture) to design, construct and commission the new RAH. Pursuant to the contractual arrangement with Project Co, the nominal capital cost for the design and construction of the new RAH by Project Co is $1849.8 million.

Under the Project Agreement, upon reaching commercial acceptance the State is required to make service payments to Project Co during the operating phase of the project. The State is not required to make service payments for the hospital until the facility is successfully completed.

Accordingly, to date, no service payments have been paid to Project Co.

4.1.5 Budget for State funded works to 30 June 2015

In addition to the works provided by Project Co pursuant to the PPP arrangement, Cabinet has approved funding elements of the project that are to be delivered and financed by the State. These works include core clinical equipment, precinct works and transition costs.

In May 2011 Cabinet approved $244.7 million for State works comprising:

- utilities infrastructure works
- ICT
- fixtures, furniture and equipment (clinical)
- project management
- contingency
- road alterations and other works.

The budget was increased by $3.4 million to $248.1 million in September 2012 to fund additional electrical supply infrastructure. The funding was required for SA Health to facilitate a cross-Government electrical infrastructure solution that incorporated elements of the deferred Rail Electrification Infrastructure Central Substation project.

In October 2014, Cabinet approved an additional $176.6 million for State works to facilitate the successful transition from the existing RAH to the new RAH. The Cabinet was advised that the additional funding was determined using a bottom up estimate of resources, capital spending needs, industry benchmarks and appropriate expert review to ensure work streams meet their functional responsibilities and contractual obligations of the State. The submission highlighted that an external consultant (the Calcutta Group) review completed in May 2014, noted significant progress was made to governance arrangements, project/contract management and transition planning. The consultant had confirmed the need to address shortcomings in a number of key areas such as ICT, clinical engagement, communications and governance. The main areas for the funding increase were:

- project office resourcing and transition activities – $66.9 million
- ICT infrastructure and transition resources – $29.2 million

- decommissioning of the existing RAH – $4.3 million
- dual running costs for a period of 73 days for running both the existing RAH and the new RAH – $17.4 million ($14.8 million including a $2.6 million funding offset)[10]
- the rollout of EPAS at the new RAH [11] – $7.3 million
- other expenditure totalling – $22.7 million.

Cabinet was advised of identified expenditure, in the form of a central contingency, totalling $35.3 million, for potential risks relating to:

- any delay costs – $10.8 million
- delays in the Distribution Centre model – $1.5 million
- not meeting the clinical equipment re-use target of 25% – $10 million
- ICT request for proposal – $13 million.

The funding request did not address any claims for not known contamination including the direct costs and time delays associated with the remediation of the site. Any successful claims were to be addressed in future Cabinet submissions. The matter of claims for not known contamination remediation is discussed in section 2.2.5.

Cabinet was also advised that if EPAS was not installed at the new RAH, alternative options could result in a subsequent submission to Cabinet for appropriate funding.

It was also advised the funding request was formed on the basis that Technical Completion and Commercial Acceptance would be reached in accordance with the contract dates. If there was any delay due to modifications or circumstances outside of the control of the new RAH program, these events would require additional review to address any potential budgetary impact once known.

The funding request was subject to a number of other assumptions including the following:

- as the project progressed, there may be a need for modifications which need to be assessed to determine the cost impact
- the holding costs of running the hospital during the period the existing hospital is being decommissioned (ie July 2016 to December 2016) were included up to December 2016 in the funding request. Once the decommissioning is completed, the vacated existing RAH buildings become the responsibility of the Urban Renewal Authority
- the approved budget for clinical equipment assumed a 25% re-use target (by value). Also a $10 million contingency was included in case the target is not achieved

[10] The funding offset represents a reduction to the budget based on the assumption that the services (ie catering, orderlies, cleaning etc) at the existing RAH would be reduced as operations are ramped down.

[11] The October 2014 Cabinet submission indicated that EPAS was initially expected to be fully rolled out across SA Health before the opening of the new RAH. It also indicated that SA Health now required funding (ie $7.299 million) to successfully transition EPAS from the existing RAH to the new RAH. This funding was subsequently removed in May 2015 following a decision not to implement EPAS at the existing RAH.

- SA Pathology identified a requirement of $8.2 million for equipment relating directly to the operation of the new RAH to be funded through the SA Health Biomedical Equipment Annual Program

- the funding request excluded any allowances for additional cost pressures across SA Health created as a result of the ramping down of services at the existing RAH and ramping up services at the new RAH.

The approved budget recognised that approximately $5.1 million of funding for the existing RAH site, predominantly associated with operational contracts and backfill for specific project roles, had been applied to offset the additional funding requirement. Further, the budget included a $1.5 million offset for staffing costs for people working on the new RAH Program, allocated from the SA Health Biomedical Equipment (BME) Annual Program to reduce the additional funding requirement.

In May 2015 Cabinet approved, as part of the 2015-16 annual budget process, the removal of $7.3 million of funding to help implement EPAS from the existing RAH to the new RAH. The funding was removed following the decision to implement EPAS directly at the new RAH.

The table below summarises the revisions to the State funded works budget since May 2011.

	May 2011 $'million	Sept 2012 $'million	Oct 2014 $'million	May 2015 $'million	Total new RAH funding $'million
Utilities infrastructure works	35.1	3.4	-	-	38.5
ICT	17.2	-	29.2	-	46.4
Furniture, fixture and equipment (clinical equipment)	148.0	-	-	-	148.0
Project management	30.5	-	7.3	-	37.8
Contingency	7.1	-	-	-	7.1
Road alternations and other works	6.8	-	-	-	6.8
New RAH Program office	-	-	64.3	-	64.3
Dual running costs	-	-	17.4	-	17.4
Outsourced procurement	-	-	10.0	-	10.0
Physical move	-	-	4.7	-	4.7
Workforce modelling	-	-	3.4	-	3.4
Enterprise rollout – EPAS	-	-	7.3	-7.3	-
Decommissioning – existing RAH site	-	-	4.3	-	4.3
Additional expenditure	-	-	35.3	-	35.3
Total project cost	244.7	3.4	183.2	-7.3	424.0
Funding offsets:					
CALHN/SA Health funding	-	-	-5.1	-	-5.1
BME funding	-	-	-1.5	-	-1.5
Total project cost (including funding offsets)	244.7	3.4	176.6	-7.3	417.4

4.1.6 Costs relating to the project not included in the project budget

During our review we noted certain costs directly related to the operation of the new RAH that are not included in the budget for the new RAH. For instance, the new RAH incorporates pathology facilities. We noted, however, the clinical equipment State funded budget ($148 million) approved by Cabinet excludes the equipment requirements for the pathology facilities at the new RAH. The cost of the pathology equipment, estimated at $8.2 million, is to be funded from the SA Health Biomedical Annual Program budget. As a result, pathology equipment costs for the new RAH are reported and monitored against the Biomedical annual capital budget rather than the new RAH State works budget.

Further, it is noted that not all direct costs associated with implementing the various ICT enterprise systems (ie EPAS, ESMI, EPLIS, iPharmacy etc) are included in the State works budget.

To ensure greater transparency in reporting the costs incurred to deliver the new RAH project, we recommend SA Health enhance existing reporting for the project. In particular, by also reporting on costs associated with the project funded from other program budgets.

This matter will be considered in the next phase of our review.

4.2 State funded project expenditure

4.2.1 Summary of project expenditure incurred from inception to 30 June 2015

Budget information and details of expenditure incurred for State funded works for the new RAH project are reported to project governance committees on a monthly basis. Details of the State funded works budget and expenditure incurred from inception to date as at 30 June 2015[12] as reported to the Committee in July 2015, are summarised in the following table.

	Current approved total program budget	Inception to date budget	Inception to date actual expenditure	Inception to date variation
	$'million	$'million	$'million	$'million
New RAH Program office	140.1	61.1	59.2	1.9
Capital works	234.9	56.6	54.7	1.9
Principal contingency	7.1	2.0	-	2.0
Total budget (excluding central contingency and funding offsets)	382.1	119.7	113. 9	5.8
Central contingency	35.3	-	-	-
Total budget (including central contingency and excluding funding offsets)	417.4	119.7	113.9	5.8

[12] The budget information as at 30 June 2015 does not reflect the financial implications of the Deed executed between the Minister for Health and Project Co on 17 September 2015.

The inception to date budget represents the budget for the project covering the period from the date the project commenced to the current reporting period.

4.2.2 Project cost pressures

The table demonstrates an underspend for State funded works of $5.8 million from inception to 30 June 2015. Notwithstanding this overall budget underspend, our review noted a project cost pressure associated with delivering ICT services for the new RAH. We noted there was an unfunded budget cost pressure of $9.6 million (excluding contingencies) and other expenditure risk items associated with delivering ICT services for the new RAH. At the time of this Report, SA Health had engaged the services of specialist ICT advisors to review the new RAH Program ICT budget and associated scope of works. This is further discussed in section 6.4.4.

5 External reviews of the new Royal Adelaide Hospital

5.1 Assurance reviews by independent consultants

SA Health has engaged an independent consultant (ie the Calcutta Group) to undertake a number of governance reviews and a functional review of the new RAH Program. The Calcutta Group, with subconsultants Accenture, has been used as specialist advisors to perform an assurance role for the program. Reviews performed by the consultant to date are:

- Governance review – June 2013
- Governance implementation review – May 2014
- Functional review – January 2015
- Governance implementation review – April 2015.

Further, in July 2015 the Committee approved the commissioning of a further review by the consultant.

5.1.1 Governance review – June 2013

The first governance review completed by the Calcutta Group was finalised in June 2013, with the report presented to Cabinet in October 2013. The scope of the review included identifying options for strengthening project governance, project/contract management and transition planning for successful commissioning of the new RAH. The consultant highlighted a number of significant matters to be addressed by SA Health including the need to:

- strengthen and refocus the governance framework
- identify all specific projects for the CALHN reform program (ie successful transitioning and commissioning of the new RAH) for coordination through a dedicated program management office
- develop a refreshed business case for the new RAH (including the CALHN reform program)
- engage additional experienced resources, including change management, operational commissioning and assurance management.

5.1.2 Governance implementation review – May 2014

The consultant's second review, completed in May 2014, was presented to Cabinet in October 2014. The review included a follow-up of the status of the recommendations made in the June 2013 review. The Cabinet submission noted that significant progress had been made in strengthening and refocusing the governance arrangements and the approach to project/ contract management and transition planning. The submission also noted the consultant identified a number of priority actions in key areas relating to:

- governance, resources and the PPP relationship
- clinical engagement
- the ICT program.

The consultant recommended the permanent appointment of a strong and experienced Program Director and ICT Project Director, supported by a properly skilled ICT team. The consultant also identified the need to review the membership of the new RAH Operations Board to reinforce accountabilities and ensure it remained a decision making body. A further matter identified related to ensuring work stream alignment with the Project Co MWP.

For clinical engagement, the consultant identified the need to develop detailed models of care and an internal communications strategy.

The consultant gave particular focus to the third area, the ICT program. The consultant found that the new RAH program was behind schedule and identified a number of risks including:

- inadequate new RAH ICT integration, delivery framework and integrated test approach and plan
- inadequate prioritisation of proposed changes and change control
- inadequate resource capability and resource planning
- insufficient local transition planning.

The consultant indicated that ICT was critical to delivering the model of care at a major contemporary hospital and highlighted the need to treat the new RAH as a high risk ICT system integration project. The consultant made a number of recommendations to address the risks including the appointment of an ICT Project Director, supported by an appropriately skilled and resourced team with end-to-end responsibility for all new RAH ICT works. The consultant also recommended evaluation of the ICT program within the strengthened governance structure.

5.1.3 Functional review – January 2015

The consultant was engaged in December 2014 to perform a functional review of the new RAH Program. The scope of the review included reviewing:

- the functionality of Program structures
- progress made in certain work streams
- the status of actions taken to improve clinical engagement
- whether Transforming Health[13] reform and the new RAH Program are able to connect.

[13] For information regarding SA Health's Transforming Health reform initiative refer to www.transforminghealth.sa.gov.au

The review noted a number of areas where progress was made including the observation that significant progress had been made in developing work stream operational plans since the last review. The review also identified a number of priority actions which included the need to:

- refocus the new RAH Operations Board
- refine the role and interfaces for additional senior resources
- communicate the program
- undertake collaborative peer reviews of the key aspects of the program.

The consultant undertook a detailed follow-up of these and other matters in April 2015. The outcome of the consultant's follow-up is summarised in section 5.1.4.

5.1.4 Governance implementation review – April 2015

The scope of the April 2015 review included following up previous recommendations and gave particular focus to: governance, resources and PPP relationships; operational commissioning; procurement; and the ICT Program. The report included an executive summary of the status of recommendations made by the consultant in their May 2014 review.

The report showed that significant progress or reasonable progress was made for most of the recommendations. There were also areas where some, limited or no progress was made. The status of the May 2014 recommendations as summarised in the report are presented in the following table.

At the time of finalising this Report, SA Health advised us that notable progress had been made to address the outstanding recommendations.

Area	Recommendation	Progress status
Governance, resources and PPP relationships	Appoint a strong and experienced Program Director, reporting directly to the Chief Executive, SA Health and the Committee, who is responsible for day-to-day management across all aspects of the new RAH Program.	Significant (appointed May 2015)
	Review the broad membership of the new RAH Operations Board to reinforce accountabilities and decision-making role.	Some progress
	Appoint experienced senior personnel with in-depth program management, health ICT and major hospital project experience.	Significant
	Appoint experienced senior personnel to support DPTI with major hospital public PPP contract experience.	Some progress
	Urgently seek to establish a realistic MWP with Project Co.	Limited or no progress[14]
	Collocate key Project Co personnel with the Integrated Program Management Office (iPMO) to facilitate a collaborative PPP relationship at a day-to-day level.	Some progress

[14] SA Health has advised that the recommendation has now been substantially addressed as a consequence of executing the Deed of Settlement and Release in September 2015.

Area	Recommendation	Progress status
Clinical engagement	Develop and implement an effective internal communications strategy and establish an escalation process for issues relating to clinician engagement.	Reasonable progress
	Establish an agreed a set of working assumptions for activity profiles to inform transition planning.	Reasonable progress
	Make a realistic assessment of the extent of change that can be safely achieved.	Limited or no progress
	Develop detailed models of care with clinicians and document them in a structured way.	Some progress
	Develop a workforce plan for each service stream, addressing industrial relations verifying key aspects of the design.	Some progress
	Clarify the role of the commissioning managers and use consistent work templates, based on established precedent.	Reasonable progress
ICT Program	Appoint an experienced ICT Program Director supported by a properly skilled and resourced team.	Significant (appointed October 2014)
	Elevate the ICT Program in the new RAH governance structure.	Significant
	Urgently develop an integrated new RAH ICT schedule to be updated and reported on weekly.	Reasonable progress
	Develop a standardised ICT delivery framework including an integrated test approach and design authority governance.	Reasonable progress
	Prioritise ‘must have’ ICT capability to support safe and deliverable models of care and develop release plans.	Some progress
	Develop contingency plans, including due dates for when the ‘go/no go’ decision needs to be made.	Some progress
	Create a Change Control Board as part of the overhaul of ICT governance.	Limited or no progress
	Review and challenge the proposed rollout approach for certain enterprise systems.	Reasonable progress
	Estimate, budget and plan transition of enterprise systems from existing RAH to new RAH.	Some progress
	Develop a local ICT transition plan.	Limited or no progress

The Committee was provided with a paper detailing the status of SA Health’s responses to the recommendations from the review in May 2015 and July 2015. The consultant’s report included a number of recommendations and highlighted a number of priority actions including the need to:

- urgently seek to establish a realistic MWP with Project Co to allow all aspects of the new RAH Program scheduling to be reflected in a realistic and commonly understood

and supported program of works. The consultant noted a need to clearly identify, monitor and communicate the critical path and realistic completion and equipment installation dates

- fast track the implementation of the recently developed action plan to develop the Operational Service Plans
- develop clinical and non-clinical move strategies, including clear lines of accountability and sign-off by CALHN
- commission or undertake a detailed expert review of the extent of building related modifications and extension of time risks
- review the clinical impacts and full costs of transferring identified equipment from the existing RAH to the new RAH
- prioritise 'must have' ICT capability to support safe and deliverable 'day one' models of care and develop contingency plans, including due dates for when key decisions need to be made
- ensure the program for implementing enterprise systems is given the highest priority, is fully coordinated with all other aspects of the MWP and is supported by realistic and detailed ICT schedule, transition, training and change management plans
- undertake detailed expert review of the planning for implementing enterprise systems.

The paper indicated that of the total 19 recommendations made by the consultant four had been completed or closed, nine were in progress and six were behind schedule. The paper also indicated a further update would be provided to the Committee in September 2015.

We understand that the Deed executed between the Minister for Health and Project Co on 17 September 2015 may address a number of the matters raised by the consultant. For instance, we understand that by executing the Deed, the risks related to project modifications and extension of time implications have been crystallised and settled with Project Co.

The full implications of the specific clauses contained in the Deed on the project, including the extent to which the Deed addresses the matters raised by the consultant, will be reviewed in the next phase of our review.

6 Detailed audit findings

6.1 Program governance, assurance and reporting arrangements

6.1.1 Assurance framework

In January 2015 the Committee was presented with a paper advising the creation of an assurance framework matrix for the new RAH project. The paper indicated that the assurance framework matrix was created to collate information about the various forms of assurance, expert advice, peer review and quality control measures used by the new RAH Program.

Review of the Committee minutes found the Committee could not endorse the framework presented as it considered it a list only for reference for each particular topic, and should be repositioned as a matrix (ie not a framework). The Committee requested further work be performed on the framework.

Our follow-up of the matter found that, at the time of our review, an assurance framework had yet to be presented to the Committee.

A paper was presented to the Committee in June 2015 regarding the role, function and reporting of the iPMO. At the meeting the Committee requested further advice relating to the program assurance including the independence of the iPMO and the benefits of undertaking formal gateway reviews.

We were advised that a proposed assurance framework was to be presented to the Committee in July 2015 for consideration and approval.

Risk exposure

The project assurance arrangements may not be fully understood by the Committee and other governance committees, creating a risk that the project or aspects of the project may not be delivered as planned.

Recommendation

We recommended SA Health ensure a robust assurance framework is approved and implemented as soon as practical.

Response

SA Health advised that a comprehensive robust Assurance Framework was approved by the Committee in July 2015. Further, SA Health advised the framework provides for a range of regular independent reviews and advice from specialist advisors as well as a formal gateway review process.

6.1.2 Role of the Integrated Program Management Office

In March 2015 the Committee discussed concerns regarding its papers. Papers were presented to the Committee in an ad hoc manner rather than by Program with resulting financial exposure. In addition, the Project Director and Program reports were not aligned with the progress of the project.

The Committee resolved for the then Acting Program Director to develop a structure to ensure independent assurance for the Committee on Program assurance and progress.

Our follow-up found this was being addressed by SA Health, and together with modifying the role of the iPMO to provide a more independent role as well as an integrated enabling and reporting function.

Risk exposure

Significant matters and progress made in delivering the project may not be effectively reported to the Committee.

Recommendation

We recommended SA Health finalise the work being undertaken to develop a structure to provide the Committee with independent assurance on the Program and progress achieved.

Response

SA Health advised that a comprehensive, robust Assurance Framework was approved by the Committee in July 2015. Further, SA Health advised that the iPMO lead was to provide the Committee with an independent statement as part of the regular monthly reporting process.

6.1.3 Reliability of reporting

Our review of the Committee and the new RAH Operations Board (the Operations Board) minutes noted members have raised concerns regarding the accuracy of iPMO reports provided to these governance committees. For instance, in meetings of March 2015 and April 2015 the Operations Board raised concerns regarding discrepancies in variances including in actual expenditure and end of year forecasts for a number of work streams.

In May 2015 the Committee raised concerns regarding:

- processes in place to report progress by the Program work streams
- discrepancies in financial reporting and internal controls over allocating contingency funding.

Risk exposure

Information provided to governance committees may not be reliable, resulting in the committees making decisions without accurate and robust information.

Recommendation

We recommended SA Health implement a quality assurance review of monthly iPMO reports provided to governance committees to ensure information contained in the reports is reliable and accurately reports the progress made by the work streams.

Response

SA Health advised that the iPMO monthly progress report is subject to quality internal control prior to being finalised. Further, consistent with the approval by the Committee in July 2015 to implement a robust assurance framework, the report is now subject to regular independent review by an independent consultancy firm. SA Health advised that the consultant's review for August 2015 indicated the report for August 2015 was of a high quality and comprehensive.

6.1.4 Review of the new Royal Adelaide Hospital Operations Board

The function of the Operations Board is to provide the new RAH Program with operational leadership and management for an integrated program and successful transition to operational commissioning.

In the May 2014 Calcutta Group review, the independent consultant recommended SA Health review the membership of the Operations Board to reinforce accountabilities and to ensure it remains a decision-making forum and remove cross-over with the role of the iPMO.

A follow-up of the matter performed by the Calcutta Group in April 2015 found that SA Health had not reviewed the membership of the Operations Board.

Our review noted that membership of the Operations Board had subsequently changed but the changes were not formally approved.

We were advised that the membership and terms of reference for the Operations Board would be formally reviewed and approved by relevant governance committees in August 2015.

Risk exposure

The effectiveness and contribution made by the Operations Board in successfully delivering the project may be diminished.

Recommendation

We recommended SA Health formally review and approve the membership and terms of reference for the Operations Board as soon as practical.

Response

SA Health advised that the terms of reference for the Operations Board were subject to informal review. They were formally reviewed, updated and approved by the Committee in August 2015.

6.1.5 Reporting by the Project Director

DPTI and SA Health entered into a memorandum of administrative arrangement (MOAA) establishing a formal arrangement for DPTI to provide services to the new RAH Program with respect to administrating the Project Agreement, including the role of Project Director as specified in the Project Agreement. The MOAA also requires regular ongoing reporting from the Project Director on the Project Agreement, including key milestones that must be met under the Project Agreement.

We noted the key milestones for reporting purposes under the MOAA were not defined or documented. We were advised that the PPP Contract Administration team:

- implemented a program report (i-Schedule) to assist SA Health identify and monitor the various obligations under the Program Agreement
- provides reporting on a number of areas of its operations.

A report by the Project Director is an established feature of the Committee's monthly standing agenda.

We noted, however, that reporting could be improved by formalising and consolidating the reporting into a single report and by providing the reporting more regularly.

Risk exposure

Not defining and regularly reporting the various obligations under the Project Agreement required by the MOAA (as part of reporting on key milestones) may result in misalignment in the understanding of the obligations by the PPP Contract Administration team and SA Health. As a consequence, key State and Project Co milestones and contractual completion dates specified in the Project Agreement may not be achieved.

Recommendations

We recommended SA Health define and document the key milestones for reporting purposes and the PPP Contract Administration work stream provide regular reports of progress made in meeting the milestones.

We also recommended SA Health formalise and consolidate reporting provided by the PPP Contract Administration work stream into a single report and ensure the report is prepared on a regular basis.

Response

SA Health advised that the PPP Contract Administration work stream will continue to provide reports to SA Health to ensure it understands the time frames for its work that may impact on State obligations and contract dates (milestones), and will continue to provide the Project Director's monthly report to governance committees.

Further, SA Health advised that in the future the PPP Contract Administration work stream will:

- ensure that all key contact dates/activities, with risks highlighted, are reported in the Project Director's monthly report
- consolidate in the Project Director's monthly report a summary of all reports provided to works streams.

6.2 Project business case

6.2.1 Completing and monitoring the new Royal Adelaide Hospital business case

Cabinet approved a business case (the Outline Business Case) for the new RAH project in 2007.

One of the expected Committee outcomes is to ensure the new RAH project is delivered against the business case.

The June 2013 Calcutta Group review identified the need to refresh (update) the business case for the CALHN reform program (and the new RAH). This included identifying capital and recurrent costs, funding sources and risks for all projects required to achieve successful operational commissioning of the new RAH.

The consultant's report highlighted that the business case is a fundamental management tool as it includes the critical parameters of the project in terms of benefits, costs, risks, scope and functional requirements. Further, the consultant highlighted that the absence of a current business case makes managing delivering the project more difficult and less defined.

The transitional funding submission approved by Cabinet in October 2014 indicated the full Business Case (ie the updated complete business case) was due for completion in November 2014.

Audit sought to gain an understanding of the status of the business case and workforce modelling which represents an important element of the business case. We noted the Committee was updated in May 2015. SA Health was still in the process of developing the updated business case and outlined the key tasks required to progress completing the business case including:

- business case gateway reviews
- the new RAH models of care and associated staffing models of care.

Our review found the Committee had received updates and a draft refreshed business case prepared by an external consultant was presented to a subcommittee. The updated full business case had not been provided to the Committee for consideration and approval.

We were advised that monitoring the project against the PPP Project Agreement and the scope of State works enables the Committee to ensure the project was being delivered in accordance with the original business plan approved by Cabinet in 2007. Further, we were advised that:

- the Committee ensures that the project is being delivered on budget and on time via monthly reporting and change management protocols
- all changes are analysed to ensure that any potential impacts to clinical outcomes and the new model of care are identified and appropriately managed
- the new RAH Program is developing a benefits realisation framework to ensure that outcomes are measured against the anticipated outcomes.

We recognise that these are important processes and tasks used to manage the delivery of the project. However, we consider that it is important that a current business case is developed to establish the critical parameters of the project including expected capital and operating costs, funding sources, risks and benefits and outcomes. These parameters will enable the Committee to more effectively monitor progress and assist with making key decisions.

Also, we considered it is important that the Committee develop a formal process to monitor the progress made in delivering the project against the parameters included in the updated business plan including current policy initiatives, the proposed capital and operating budget and model of care.

The urgency of this matter becomes more significant as the new RAH approaches commercial acceptance and the work streams make decisions that affect the future operations of the hospital. For instance, the Procurement work stream is progressing procurements and executing contacts for the project that have ongoing operating cost implications (ie whole-of-life costs). These procurements and resultant financial commitments are being initiated and completed in the absence of a formal approved budget for the whole-of-life costs and without the oversight of the Committee.

Risk exposure

The capital costs, operating costs, funding sources and the risks associated with delivering the CALHN reform program (and the new RAH) may not be fully understood and the intended outcomes and benefits of the project may not be realised.

Recommendations

We recommended SA Health:

- complete the full business case for the CALHN reform program (and the new RAH) as soon as practical
- continue to monitor and update the business case as the project progresses through its lifecycle
- develop a formal robust process to monitor the progress made in delivering key aspects of the project against the key parameters included in the updated business plan.

Response

SA Health acknowledged the recommendations and indicated that it will continue updating the business case through its lifecycle. Further, we were advised that the 'as is' business case refresh (that is based on existing models of service delivery) has been completed. SA Health is currently mapping the workforce profile to the proposed models of service delivery and undertaking scenario testing with the aim of completing the next update of the Business Case by the end of October 2015.

SA Health also advised that a Business Case Subcommittee to the Committee has recently been established and will be the vehicle to monitor progress against the key parameters included in the business case.

6.2.2 Monitoring of whole-of-life costs

Procurements of State funded furniture, fixtures and equipment (ie clinical equipment) include whole-of-life costs (ie ongoing operating costs).

As previously indicated the Committee has a role in considering whole-of-life costs.

In the absence of a current business case, we sought to gain an understanding of the mechanism established to monitor whole-of-life costs associated with procurements of clinical equipment for the new RAH. We made enquiries as to whether a budget had been established and approved for the new RAH whole-of-life costs and how amounts expended and committed were managed against the budget.

Our review found that a budget for whole-of-life costs had not been established. Further, we found that whole-of-life costs are not reported and therefore monitored by the Committee or the Operations Board.

Risk exposure

Ineffective reporting and monitoring of the whole-of-life costs could result in future budgetary cost pressures for the new RAH.

Recommendations

We recommended SA Health establish a formal approved budget for the whole-of-life costs for the project.

Further, we recommended SA Health develop and implement a process for reporting and monitoring whole-of-life costs by the Committee.

Response

SA Health responded to the finding and advised that the Project Agreement includes provision for Project Co to manage the capital replacement of building elements and the associated whole-of-life costs. Further, in terms of equipment, whole-of-life of costs are monitored as part of the overall business case. The budget for whole-of-life costs is developed on an annual basis through the budget process.

We note the response provided by SA Health and consider it is important to reaffirm our view that it is important that the process undertaken by the Committee to monitor relevant whole-of-life costs against an approved budget is appropriately documented.

6.3 Risk management

6.3.1 Reporting of risks and mitigation strategies

A key feature of sound project management is establishing effective risk management processes and practices including the identification, implementation and ongoing monitoring of risk mitigation strategies.

Since September 2014 a Strategic Register has been presented to the Committee. The register listed extreme, high and some moderate risks and provided a very brief and general description of each risk. In many instances the risk description was vague and did not convey a sufficient understanding of the nature the risk and the consequence of the risk to the project and the State.

Further, the risk register did not include details about the strategies implemented to mitigate the risk or the current status of the strategies.

A number of the risks relevant to delivering the project involve significant complexity and if realised, would have material consequences to the State in terms of meeting the intended benefits and time frames, patient safety and financial exposure.

We consider that the individuals charged with the responsibility to monitor and manage the risks need to fully understand the nature of significant risks, consequences and the status of strategies to manage or mitigate the risks.

Risk exposure

The true nature of the project risks, exposures and status of mitigation strategies may not be fully understood by the Committee and therefore may not be appropriately managed.

Recommendations

We recommended that SA Health revise the risk information to ensure it provided the Committee with a better understanding of the nature and consequences of the strategic risks.

Further, we recommended information include details of strategies implemented to mitigate identified risks and the status of the strategies.

Response

SA Health advised that risk reporting to the Committee has been progressively improved. In June 2015 the reporting was expanded to include the status of treatment measures for strategic risks. In addition, from August 2015 risk reporting included a summary of controls, treatments and an independent assessment of the status of each risk provided by the iPMO.

6.3.2 Other areas of risk management practices requiring improvement

Our review of risk management arrangements and information (in the form of risk registers) provided to the Committee and the Operations Board identified a number of areas requiring improvement and attention by management. The main matters included the following:

- there was a lack of policy guidance regarding who can approve key changes made to information recorded in risk registers. Further, the basis and approval for adding or removing risks from the registers were not always documented
- instances where the risk names and descriptions varied from register to register making it difficult to identify specific risks from one register to another and to track them from month to month
- due treatment dates for risks recorded in the Strategic Risk Register had elapsed without being updated
- inconsistencies between risk information recorded in the Strategic Risk Register provided to governance committees (prepared by the iPMO) and the risk information prepared and provided by the Project Director.

Risk exposure

Members of key governance committees may not be aware of or understand the basis for changes made to risk information recorded in risk registers.

Project risks may not be effectively managed.

Recommendations

We made a number to recommendations to SA Health to address the matters raised including:

- establishing policy guidance regarding who can approve key changes to risk information recorded in risk registers and implementing a mechanism to ensure compliance with the policy
- ensuring key changes (ie addition and removal of risks) made to information recorded in risk registers presented to governance committees are highlighted and disclosed to the committee
- implementing a mechanism to ensure consistency in the information recorded in risk registers and improving relevant policy guidance.

Response

SA Health advised actions taken to address the matters raised. The key aspects of the response included:

- establishing the new RAH Integrated Risk and Program Committee in August 2015 which will recommend changes (including the addition and removal) to strategic risk information for approval by the Committee
- assigning new RAH project risks with a unique ID, implementing monthly reviews of risk information and providing additional policy guidance documentation.

6.4 Budgetary and financial management

6.4.1 Reporting to the new Royal Adelaide Hospital Steering Committee

It is important that governance committees and individuals charged with responsibility for ensuring projects are delivered within cost parameters and the intended benefits of the project are realised, are provided with budget and financial information that is timely, relevant and reliable.

The comparison and analysis of actual expenditure against the project budget and forecast represents an important budgetary and financial management control over projects.

We assessed the budgetary and financial information provided to the Committee. We found the nature and extent of information provided to the Committee varied throughout the period of our review and we identified a number of areas requiring improvement which were communicated to management. The specific matters raised with SA Health included:

- the budget and finance reports provided to the Committee did not provide a comparison of project to date actual expenditure against the project to date budget and forecast. The Committee was only provided with a comparison of year to date actual expenditure against year to date budget
- budget and finance reports provided to the Committee did not provide commentary or explanations for significant variances between actual expenditure and budget/forecast figures included in the reports

- reports providing details of project modifications and change requests did not indicate how the costs associated with the modifications/change requests were to be funded

- there was scope to improve information provided to the Committee regarding the project modifications and change requests including commentary describing the nature of the major items reported and the reasons and significance of major changes from month to month

- the need to ensure that the basis and approval of adjustments made to the new RAH budget as reflected in the budget and finance reports presented to the Committee are appropriately documented and approved.

We noted that SA Health had progressively revised the format and content of the budget and financial reports presented to the Committee subsequent to our review which may address the identified matters. For example, at July 2015, the format of budget reports included inception to date and modification data.

Further, we noted that SA Health established a new RAH Finance subcommittee which first met in March 2015. This subcommittee provides an oversight function for the new RAH program finances.

The revised format and content of the budget and finance reports will be reviewed as part of the next phase of our review.

Risk exposure

Significant variations between actual expenditure and the project budget and forecasts may not be identified, analysed and actioned on a timely basis.

The reasons for significant variances between actual expenditure and the project budget/ forecasts may not be appropriately investigated and clearly understood.

Expenditure commitments associated with project modifications and variations may not be effectively managed resulting in project expenditure exceeding the approved project budget.

The status and significance of project modifications for the project budget may not be clearly understood and monitored by the Committee.

Adjustments to the project budget may not be clearly understood by the Committee which may limit its capacity to make informed decisions.

Recommendations

We recommended SA Health review and revise budget and financial information provided to the Committee to ensure the information provided includes:

- a comparison of project to date actual expenditure against the project to date budget and forecast

- appropriate commentary explaining significant variations between actual project expenditure and the project budget/forecasts

- details of how project modifications and change requests reported to the Committee are to be funded

- a summary of the major items comprising project modifications and change requests and commentary regarding the reasons and significance of changes in reported items from for one month to the next month.

We also recommended a framework be developed for approving adjustments to the new RAH project budget and ensure the basis of adjustments to the budget are clearly reported to the Committee and appropriately approved.

Response

SA Health responded to the detailed findings and provided details of actions implemented to address the matters raised including:

- inclusion of an 'inception to date actual field' which records total expenditure to date across the Program

- providing the Committee, from June 2015, explanations of variances and other commentary, as presented to the Finance subcommittee

- inclusion of, in July 2015, a full reconciliation of design development modifications including details of modifications where final prices had not been agreed and approved the reservation of sufficient funds from the Program Contingency

- providing the Committee, from June 2015, details of major changes to the expected costs of modifications.

6.4.2 Reporting of project forecasts

Our review of the budget and finance reports presented to the Committee found that expenditure forecasts for the project commenced being included in the reports from March 2015 onwards.

Further, our review found that for most budget lines there were varying levels of documentation to support the forecasts. We found that the forecasts were not derived from actual expenditure to date, actual and expected commitments, known cost pressures and estimates of amounts still required to be spent to complete outstanding tasks required to deliver the project.

Risk exposure

Project cost pressures may not be fully identified and addressed on a timely basis.

Recommendations

We recommended SA Health review and update the process of establishing project forecasts to ensure they are derived from actual project expenditure incurred to date, actual and expected commitments, known cost pressures and estimates of amounts required to be spent to complete outstanding tasks required to deliver the project.

Further, we recommended SA Health document how forecast amounts are determined for future reference and consistent report preparation.

Response

SA Health advised that an undocumented process had existed for some time to provide an understanding of individual work stream forecasts and cost pressures and to enable comparison against budget. SA Health advised that good practice should include greater transparency of this process through documentation of the process.

6.4.3 Management and reporting on the project contingency

The State funded works budget, approved by Cabinet in October 2014, included a principal contingency of $7.082 million and a further contingency of $35.5 million for potential additional expenditure that may arise from delay scenarios, timing risks and risks associated with the distribution centre, clinical equipment re-use and ICT.

When we commenced our review, the new RAH Finance work stream was developing a contingency report. A report was subsequently provided to the Committee in May 2015. The report included numerous expenditure items including approved amounts, adjustments, cost pressures and identified risks and opportunities. However, the report did not clearly convey the status of the project contingency. For instance, the report did not clearly disclose which project modifications/variations/cost pressures were actually allocated against the contingency, the remaining contingency balance yet to be allocated and the items that were still being evaluated.

We considered that the information provided to the Committee was insufficient to enable the Committee to determine which items were actually allocated, the basis of allocation and who approved them. Further, we noted that there was a lack of policy guidance regarding the timing and circumstances when it is considered appropriate to allocate amounts against the contingency and the required approval process.

We also noted that in May 2015 the Committee recorded a concern regarding the financial reporting and the process for allocating contingency funding.

In June 2015, the Committee was presented with a paper recommending changes in the way project contingency funds are managed, applied and reported. The paper also included draft guidelines for project contingency fund management. The Committee endorsed the recommended approach to managing, accessing and reporting project contingency funds and requested a number of amendments to the guidelines.

These changes in processes and reporting will be reviewed as part of the next phase of our review.

Risk exposure

Ineffective management of the project contingency may result in project expenditure exceeding the approved project budget.

Recommendation

We recommended SA Health ensure that information regarding the project contingency, which clearly discloses the status of the project contingency, is provided to the Committee on a regular basis. Further, we recommended SA Health ensure the concerns within the Committee regarding the process for allocating the contingency were appropriately addressed.

Response

SA Health confirmed that the Committee approved guidelines for the management of contingency funds for the new RAH Program and the status of the project contingency has been reported within recent Monthly Progress Reports to the Committee.

6.4.4 Funding new Royal Adelaide Hospital ICT Program cost pressures

In October 2014, Cabinet approved an increase to the State funded works budget for the new RAH project. This approval provided an additional $36.505 million to deliver the new RAH ICT Program. The approval also included an additional $13 million contingency for a request for proposal to outsource ICT services. As a result of the October 2014 Cabinet approval the total budget for the new RAH ICT State funded works was $66.715 million. In May 2015, Cabinet approved, as part of the 2015-16 annual budget process, the removal of $7.299 million funding allocated for the rollout of EPAS from the existing RAH to the new RAH. The funding was removed following a decision to roll out EPAS directly into the new RAH. The approved budget for the new RAH Program following the removal of the EPAS transition funding is summarised in the following table.

	New RAH ICT Program budget originally approved by Cabinet	Additional transition funding approved by Cabinet in October 2014	Adjustment to budget approved by Cabinet as part of the 2015-16 budget process	Current new RAH budget approved by Cabinet
	$'million	$'million	$'million	$'million
ICT	17.210	29.206	-	46.416
Enterprise rollout – EPAS	-	7.299	(7.299)	-
Total	17.210	36.505	(7.299)	46.416
Additional expenditure				
Request for proposal – contingency	-	13.000	-	13.000
Total	17.210	49.505	(7.299)	59.416

Our review noted that the budget for the new RAH ICT Program was subject to cost pressure and/or other expenditure risk items. In June 2015, the new RAH Finance work stream presented a summary report on the status of the new RAH ICT Program budget to the Committee. The report indicated that the estimated cost of the program exceeded the budget by $12.77 million, allowing for the $13 million ICT contingency centrally held by the

Treasurer (which had yet to be allocated and approved by the Treasurer). The report indicated a cost pressure of $9.6 million and identified other expenditure risks items (totalling $16.2 million) associated with delivering ICT services for the new RAH. The major cost pressures and other expenditure risk items detailed in the summary were:

- ESMI
- EPAS transition costs or alternative solution (including the legacy contingency Acute Patient Management System)
- in-built coverage for mobile, paging and two-way radio services
- outpatient queuing management originally incorporated into EPAS.

We were advised that SA Health was in the process of reviewing the new RAH ICT Program budget including reviewing the scope of ICT works.

The expenditure risk item relating to the EPAS transition or alternative solution relates to works incurred by the new RAH ICT work stream in helping to transition EPAS into the new RAH, which are not funded and managed centrally through eHealth services. This includes developing a contingency solution in case EPAS was not implemented at the new RAH.

We found that the potential funding shortfall and resultant cost pressure relating to this matter was not reported to the Committee on a timely basis.

Risk exposure

The costs associated with delivering ICT services for the new RAH Program may exceed budget.

Project cost pressures may not be identified and addressed on a timely basis, resulting in the need to allocate additional funding to successfully deliver the project.

Recommendations

We recommended SA Health finalise the review of the new RAH ICT Program budget and the report the outcome to the Committee as soon as practical.

We also recommended SA Health determine how the cost associated with helping to transition EPAS at the new RAH is to be funded as soon as practical.

Further, we recommended SA Health report the status of this matter to the Committee on a timely basis until such time it is resolved.

Response

SA Health advised that as part of the broader Assurance Framework approved by the Committee in July 2015, an independent review of the new RAH ICT work stream and associated scope of works was commissioned. The review is to be completed by specialist ICT advisors and is due for completion by the end of October 2015.

SA Health, also advised that most costs associated with implementing EPAS at the new RAH are funded and managed centrally through eHealth Services. The new RAH ICT work stream is assisting the transition of EPAS into the new RAH. The estimated cost associated with these works was presented to the Committee in July 2015 and a specialist ICT advisor was subsequently engaged to assist with validating the scope of works.

6.4.5 Information to support funding requests to Cabinet

We sought to understand the basis and information prepared to support the ICT component funding request provided to Cabinet in October 2014.

The new RAH ICT Program budget included in the Cabinet submission considered the following:

- a recommended organisation structure by an independent consultant (the Calcutta Group)
- an assessment undertaken by ICT Health, which was predominantly based on a request for proposal developed in July 2014
- a benchmarking exercise undertaken against the Gold Coast Hospital and Health Service project.

Our review found that there was scope to improve the level of documentation to support the detailed analysis of the specific tasks, deliverables, resources and time frames required and associated risks for the additional funding request. Further, we found that there was a lack of workings and documentation to support calculations, significant estimates and key assumptions. We were advised that the lack of funding available at the time to recruit expert resources contributed to the lack of detailed analysis, workings and documentation.

Risk exposure

A lack of realistic budget which may limit the effectiveness of the budgetary control over the new RAH ICT Program.

Recommendation

We recommended SA Health ensure funding requests provided to Cabinet are supported with appropriate documentation, rigorous estimates, sound assumptions and robust analysis of relevant data and information.

Response

SA Health advised that it worked closely with the Department of Treasury and Finance to prepare the funding submission based on the best information (ie known scope of work and level of detail as well as the project risk profile) available at the time. SA Health also advised that it noted the recommendation and future Cabinet submissions will continue to be supported by the appropriate level of documentation, assumptions, analysis and information.

6.5 Contract administration and management

6.5.1 State funded clinical equipment – contract management framework and plans

The Strategic Acquisition Plan for State funded furniture, fixtures and equipment (ie clinical equipment) indicates that the procurement of clinical equipment for the new RAH represents the single largest procurement program for the public health sector. The plan estimates that approximately 9000 items are to be procured or transferred to the new RAH, with an estimated cost of $207 million ($148 million excluding the equipment items that are to be reused and pathology equipment that is to be funded separately from other program annual budgets).

The procurement program and installation of the clinical equipment requires establishing, executing and administering a large number of contracts with different values, risks and complexities.

We consider that a robust contract management framework together with contract management plans are important tools for effectively managing the risks, obligations and expected deliverables for each of the contracts established to meet the contractual requirements of the Project Agreement and the functional requirements of the new hospital.

Our review included gaining an understanding of the framework established to administer and manage the contracts established in delivering the procurement program for the new RAH.

We found that, at the time of our review, SA Health was in the process of developing a contract management framework and contract management plans for the clinical equipment procurement program.

Risk exposure

The absence of an approved contract management framework and plans increases the risk that obligations and deliverables associated with contracts established to deliver the Program may not be effectively managed, resulting in expected functional requirements of the hospital not being met and financial loss to the State.

Recommendations

We recommended SA Health finalise and approve the contract management framework and contract management plans, including defining ongoing contract management responsibilities, as soon as practical.

Further, we recommended SA Health establish a process to monitor progress made in delivering the key requirements detailed in the plans.

Response

SA Health advised that a contract management framework for managing vendors, contractual obligations and expected deliverables for State funded clinical equipment has been finalised and is expected to be approved by the Committee in October 2015. The framework aligns

with the contractual obligations within the Project Agreement and functional requirements of an operational hospital. SA Health also advised that contract management plans for clinical equipment were nearing completion.

6.5.2 Professional service and ICT contracts – contract management processes

The delivery of the new RAH project is supported by a range of contracted professional services.

Our review found SA Health was in the process of reviewing the status of professional services contracts established for the new RAH project. We understood that the review was implemented following concerns raised by CALHN management as to whether executed contracts or contract variations, reflecting the services currently being provided, were in place for all contractors. We were advised that a number of the arrangements with contracted service providers date back to the early stages of the project and had not been updated to reflect current services/arrangements in place with the service provider.

We requested details of the contracts that were in the process of being reviewed and/or the required action. SA Health advised there were nine contracts with an aggregate value of $15.6 million for which action was required to execute contract variations to reflect current services provided, obtain a signed copy of the contract or determine whether a contract variation was required.

Further, we found that SA Health was in the process of identifying the quantum, value and status (in terms of execution) of contracts relating to the provision of ICT services for the new RAH project. We were advised that the new RAH Program Director, the new RAH ICT Program Director and the Director Financial Planning and Analysis for the new RAH were reviewing the new RAH ICT Program budget and related cost pressures. The review also included identifying the quantum and status of ICT contracts.

As a consequence, at the time of our review we could not be provided with a list of ICT contracts detailing their value and contract status.

Risk exposure

Ineffective management and administration of contracts resulting in project cost pressures.

Recommendations

We recommended SA Health:

- implement a mechanism to ensure contracts and/or contract variations are executed to reflect the services currently being provided
- complete the review of the quantum and status of ICT contracts as soon as practical
- finalise the execution of all outstanding contracts and contract variations.

Response

SA Health advised that the new RAH Procurement work stream has recently established a more effective contract management process that can be used by nominated contract managers to ensure contracts are current in terms of scope, time frames, deliverables and value.

6.5.3 PPP Contract Administration – contract management framework

The State has entered into a Project Agreement with Project Co to design, construct, finance, maintain and provide facility management services for the new RAH. The term of the agreement is 35 years. The agreement establishes complex contractual arrangements between Project Co and the State. These include strict contractual obligations for project delivery and require key tasks to be delivered by the State within specified dates.

Effective contract management is essential for ensuring parties to the contract meet their contractual obligations. A contract management plan is a tool by which the key strategies, activities and tasks required to manage the contract are documented and assigned to specific staff to ensure all parties fulfil their contractual obligations.

Our review found that the PPP Contract Administration work stream established two contract management manuals to assist with the administration of the new RAH Project Agreement. The manuals are comprehensive and provide valuable guidance in ensuring key clauses of the agreement are complied with.

The manuals did not identify who was assigned responsibility for ensuring compliance with specific clauses of the agreement and did not provide for regular monitoring and reporting of progress.

We were advised that the work stream uses the i-Schedule tool to assist with the scheduling of work flows and tasks, however these are not mapped back to specific requirements (ie clauses) included in the Project Agreement. We consider that contract management practices would be greatly enhanced if the responsibility for ensuring compliance with specific clauses of the Project Agreement is documented in a contract management plan and progress made against the plan is monitored and reported on a regular basis.

Risk exposure

Responsibility for ensuring key contractual requirements specified in the Project Agreement may not be assigned to an officer, resulting in the State not meeting its contractual requirements and incurring financial loss.

Recommendations

We recommended SA Health develop and implement a contract management plan that documents which officer has been assigned responsibility for ensuring key clauses of the new RAH Project Agreement are compiled with.

Further, we recommended SA Health implement regular monitoring and reporting of progress made against the plan.

Response

SA Health advised that the Project Director (DPTI) is the responsible officer for all the rights and functions under the agreement. Further, the Project Director has assigned day to day responsibilities to members of the PPP Contract Administration work stream and these will be

documented in the Contract Management Manual – Design and Construction. We were also advised that the Contact Management Manual – Operating Term is currently in development and will include a responsibility matrix for activities assigned to the Contract Administrator and those assigned to the Facility Operator.

SA Health also advised that the Project Director has recently implemented a weekly management meeting that monitors key deliverables and decisions to ensure they are timely and appropriately resourced.

6.5.4 PPP Contract Administration – reporting arrangements

As previously indicated SA Health and DPTI established a formal arrangement (ie MOAA) for DPTI to provide services to the new RAH Program with respect to the administration of the Project Agreement.

The MOAA requires regular ongoing reporting from the Project Director in relation to the Project Agreement.

Our review of the contract management arrangements included reviewing the reporting provided by the Project Manager (through the PPP Contract Administration work stream) to the Committee. We found a number of areas where there was scope to improve reporting to the Committee. These included:

- the need to improve controls and reconciliation procedures to ensure information included in the reports is complete and accurate
- explanations were not always provided in the reports where details of modifications and liability items and balances varied significantly from month to month
- the discretionary/non-discretionary classification of modifications and liability items included in the reports were not always clear.

Risk exposure

The information recorded in the contact administration reports provided to the Committee may not be complete and accurate or may lack clarity resulting in the Committee making key decisions on information that is unreliable or not clearly understood.

Recommendations

We made a number of recommendations to SA Health to address the specific areas identified requiring improvement and management attention including:

- implementing a reconciliation of modification and liability information to ensure information provided is complete and accurate
- providing the Committee with explanations for items and balances that have significantly varied from month to month, and maintaining an audit trail of changes
- reviewing and revising the classification of discretionary and non-discretionary for modifications/liability items.

Response

SA Health responded to the findings and provided details of actions already taken or proposed to address the matters raised.

6.6 ICT functional and contractual dependencies

6.6.1 Planning for enterprise systems and coordination of works with the Master Works Program

As mentioned in section 5.1, SA Health has engaged an independent consultant (the Calcutta Group) to undertake a number of assurance reviews over the new RAH project. Their third review completed in April 2015 included examining the new RAH ICT Program. The external consultant found that the eHealth business-as-usual mode of operation was unlikely to provide sufficient timely output for the new RAH Program, due to the eHealth team being responsible for the entire SA Health system. The external consultant recommended that SA Health ensure the implementation of the enterprise systems at the new RAH is:

- given the highest priority
- fully coordinated with the MWP
- supported by detailed schedule and transition, training and change management plans.

Our review included gaining an update on the remediation status of the external consultant's recommendation. SA Health advised that the new RAH Program approach is to ensure that the implementation of the enterprise systems has no bearing on the MWP. The use of either legacy systems (mitigation) or the new enterprise systems is anticipated to provide Project Co with its requirements and this is currently planned and being actioned. Further, the new RAH ICT Program is working with the enterprise programs to identify the detailed plans which are at differing levels of maturity and completeness depending on the program.

Risk exposure

The implementation of the enterprise systems and ICT works may not meet the time frames provided for in the MWP resulting in delays to Project Co's work program, therefore causing delays in delivering the project and associated delay costs.

Recommendation

We recommended that SA Health, finalise the planning for implementing the enterprise systems into the new RAH as soon as practical.

Response

SA Health advised that the MWP is a Project Co schedule and reflects work being delivered by Project Co. Relevant information within the MWP is used within the iPMO Integrated Schedule (i-Schedule) used by the State for its planning. SA Health advised that the new RAH ICT Program is working with enterprise system implementation programs to ensure key milestones are reflected in the schedule.

6.7 Procurement

6.7.1 State Procurement Board governance and reporting arrangements – clinical equipment

SA Health prepared a Strategic Acquisition Plan (the plan) for the procurement of State funded furniture, fittings and equipment (ie clinical equipment) for the new RAH. The plan, which was comprehensive and detailed the proposed procurement program and strategy, was provided to the State Procurement Board (SPB) for consideration and approval. The plan indicated that ongoing governance by the SPB over the project would be achieved through quarterly reporting to the SPB.

In approving the plan in December 2013, the SPB noted that SA Health is to provide quarterly reports to the SPB on the progress of the procurement for the project. The plan proposed that the reporting to the SPB was to include details of:

- acquisition plans approved in the last quarter
- purchase recommendations approved in the last quarter, including details of successful vendors, final capital cost against budgeted cost and benefits achieved
- procurement bundles to be commenced in the last quarter
- procurement bundles to be commenced in the next quarter
- status of current tenders in progress
- procurement budget update.

Our review found that reporting to the SPB was not consistent with what was proposed in the Strategic Acquisition Plan and did not enable the effective monitoring of progress of the procurement project in accordance with the plan.

Reports were not provided to the SPB on a quarterly basis as proposed in the plan and noted by the SPB in its approval of the plan. Updates were only provided to the SPB in September 2014 and April 2015.

Our review also found that the format and content of reporting to the SPB varied significantly. The update provided to the SPB in September 2014 comprised a paper provided to the Committee providing an update on the procurement project. In April 2015 the SPB was provided with a new RAH approvals schedule. We noted, however, that the information provided did not include the majority of the information required in the plan approved by the SPB.

Risk exposure

The procurement of clinical equipment items for the project may not be undertaken in accordance with the strategy detailed in the Strategic Acquisition Plan approved by the SPB.

The format and content of reporting provided to the SPB may not facilitate effective monitoring of the procurement project against the approved plan.

Recommendations

We recommended SA Health ensure project procurement progress reports of clinical equipment are provided to the SPB quarterly in accordance with the approved Strategic Acquisition Plan.

In addition, we recommended SA Health review and revise the format and content of the information provided to the SPB to ensure it is consistent with the reporting proposed in the Strategic Acquisition Plan and enables effective monitoring of progress of the procurement project against the approved plan.

Response

SA Health indicated that a quarterly report would be provided to the SPB which will provide a status update that covers the procurement process through until the end of the third quarter of 2015. Future reports will be provided to the SPB at the agreed frequency.

SA Health also advised that although not specifically raised as a concern by the SPB, the format and content of the reporting to the SPB will be aligned to what was detailed in the Strategic Acquisition Plan and will provide a status of all clinical equipment tender groups.

6.7.2 Probity assurance arrangements

SA Health has engaged a consultancy firm to provide probity assurance services for the procurement of State funded furniture, fittings and equipment (ie clinical equipment). We considered the agreement with the firm did not provide sufficient details regarding the nature and extent of services provided, the key deliverables and reporting requirements. For instance the agreement did not specify:

- the type of probity assurance services to be provided (ie probity audit or probity advice)
- how the scope of review was determined (ie how the bundles are to be selected)
- whether the consultant is to give an opinion over the probity of specific bundles or the overall procurement process
- the nature, extent and scope of reporting responsibilities
- roles with respect to managing conflicts of interest
- services included in evaluating compliance with the Strategic Acquisition Plan and Detailed Acquisition Plans
- roles with respect to reviewing post-evaluation negotiations with preferred tenderers.

The consultancy firm commenced providing services in February 2014 after the procurement process commenced (ie August 2012). The agreement with the consultant included conducting a high level review of procurements already undertaken or in progress. SA Health advised, however, that this did not include forming an opinion as to whether or not the procurement breached probity requirements.

The SPB Guidelines provide that, if required, the use of a probity advisor can be considered for procurements assessed as high in complexity and value. We understand that the Hyperbaric Chamber bundle procurement, which commenced prior to the engagement of the probity advisor, was assessed as high in complexity and value.

We were also advised that the consultancy firm was asked to provide probity assurance services for procurements relating to the new RAH ICT Program. SA Health had not entered into an agreement with the consultancy firm confirming the specific details of the arrangements including the nature and scope of services, deliverables, fee arrangements and reporting responsibilities.

We consider that for large and complex procurement projects, where it is assessed that it is appropriate to engage the services of a probity advisor, they should be engaged prior to commencing the procurement process.

Risk exposure

A gap may occur between the expected and actual level of probity assurance provided.

Key procurement processes may not be subject to the timely probity assurance services.

Recommendations

We recommended SA Health document and agree in detail the nature and extent of probity assurance services provided, key deliverables and reporting requirements.

In the future, SA Health ensure probity assurance services for major procurement projects are engaged prior to commencing the procurement process.

We recommended SA Health enter into a formal agreement with the consultancy firm engaged to provide probity assurance services for the new RAH ICT Program.

Response

SA Health advised that a variation to the scope of the probity advisor's contract has been issued that identifies ongoing probity involvement through the contract management phase. The probity plan lists the appropriate interfaces with probity advisors around supplier performance, compliance with the law and applicable standards, dealing with supplier problems and post-contract execution. The Probity Advisors have identified the appropriate points throughout the contract management phase to conduct a probity review. This has been considered by SA Health and incorporated into responsibility and process checklists.

Regarding the commencement of probity services, SA Health noted our recommendation and advised that most project environments require compliance with strict time constraints and it is sometimes necessary to commence many key and strategic activities in parallel. The engagement of probity assurance services required a procurement process in parallel with establishing the clinical equipment procurement process.

In addition, SA Health advised that a contract variation has been prepared to include ICT procurement within the scope of the existing contracted probity assurance services.

6.7.3 Reporting on the status of procurements – clinical equipment

The Project Agreement between the State and Project Co specifies time frames for the procurement and installation of State funded furniture, fixtures and equipment (ie clinical equipment). Any failure in meeting the installation dates may be determined by Project Co as causing delays to the MWP, which could result in financial consequences to the State.

At the time of our review, the information provided to the Committee did not effectively report, on an ongoing basis, the status and key risks associated with the procurement and installation process in terms of the State meeting the time frames specified in the Project Agreement. We noted inconsistencies in the information provided to the Committee regarding the progress, status and risks associated with the procurement project. Similarly, we noted that in February 2015, the Committee expressed concerns that there were conflicting reports on the procurement project schedule status.

Following our review, SA Health advised that it had developed and implemented improvements in systems and reporting on the status and risks associated with the procurement of furniture, fixtures and equipment.

These improvements will be reviewed as part of the next phase of our review.

Risk exposure

Ineffective monitoring and reporting of the status of the procurement and installation of State funded furniture, fixtures and equipment may result in not meeting the installation dates specified in the MWP and incurring monetary penalties by the State.

Recommendation

We recommended SA Health ensure reliable reports are provided to the Committee on an ongoing basis which effectively report the status and risks associated with meeting the installation of dates specified in the MWP. Further, we recommended SA Health ensure the reporting includes regular updates on the effectiveness of mitigation strategies implemented for identified risks.

Response

SA Health indicated the status and risks associated with meeting installation dates in the MWP are reported to the Committee through a number of reports including the Project Director's report. From June 2015 a furniture, fixtures and equipment dashboard has been added to the reports provided to the Committee.

6.7.4 Reporting on installation dates – clinical equipment

The Project Agreement requires clinical equipment to be installed within time frames provided for in the MWP. Generally, fixed clinical equipment is required to be installed in accordance with the MWP prior to the joint commissioning period, while mobile clinical equipment is required to be installed during the joint commissioning period.

Failure to meet installation dates as provided for in the MWP could result in delays in Project Co's work program which could result in delays to the project and delay costs incurred by the State.

The Strategic Acquisition Plan lists due installation dates for key procurement bundles based on the version of the MWP in place at the time the plan was prepared. Our review of the list noted that a significant number of the installation dates required revision.

We sought to obtain an understanding of the status and mechanisms in place to ensure required installation dates, as provided for in the MWP, are met. We were advised that there were a number of mechanisms established (some informal) for the day-to-day management of the installation of clinical equipment including:

- agreeing acceptable installation dates for fixed clinical equipment items for incorporation into the MWP during regular State Works Coordination meetings
- establishment of the new RAH Procurement and Installation Working Group meeting for coordinating and managing procurement, installation timetables and resources requirements between different teams
- the PPP Contract Administration team establishing a presence on site from May 2015 to monitor the State's compliance with the Project Agreement.

We recognise that these are important activities, however our review found SA Health was not able to provide us with a concise report(s) that effectively communicated the following:

- items of equipment installed in accordance with the MWP
- items of equipment not (or not likely to be) installed in accordance with the MWP, their status and the impact (if any) on the MWP critical path
- items of equipment where changes to the installation date are being negotiated or still to be negotiated with Project Co.

Further, we noted that there was a lack of reporting provided to the Committee regarding progress made with respect in installing specific clinical equipment bundles against the time frames agreed to in the MWP.

Risk exposure

Ineffective monitoring of progress made in installing clinical equipment resulting in potential contractual or financial exposure/consequences.

Recommendations

We recommended SA Health develop and implement effective reporting of progress made in installing clinical equipment in accordance with the requirements of the MWP.

In addition, we recommended SA Health provide regular reports to the Committee on progress made on specific procurement bundles including areas of concern, outstanding actions and potential contractual or financial exposure/consequences.

Response

SA Health advised that a series of workshops was held with Project Co to fully assess and agree all target installation dates for fixed clinical equipment. The MWP now reflects those agreed install dates and an assessment has been made against building and commissioning impact to further inform potential mitigation strategies for any dates at risk of not being achieved.

Further, SA Health advised that following implementing the above activities to address the matters raised, detailed monitoring and reporting was developed to track and mitigate all impacts of clinical equipment bundles that have an installation forecast date that is later than agreed or poses a MWP critical path risk. Also, the Committee now receives updates on progress made on specific procurement bundles that are considered high risk including areas of concern, outstanding actions and potential contractual or financial impact.

6.7.5 Renegotiation of installation dates – clinical equipment

The dates for installing State funded furniture, fixtures and equipment (ie clinical equipment) incorporated into the MWP were determined prior to the State finalising the procurement and selection of specific items of equipment. As a consequence, for some items of equipment, Project Co are required to make modifications to the facility to accommodate the installation of the equipment.

The monthly report from the Project Director provided to the Committee in June 2015 noted that for a number of items there was a high risk that later installation dates were required. This was due to the need for Project Co to complete modification works and new dates needing to be negotiated. In the report, the Project Director noted that as the modifications and installations were arising late in the MWP the situation presents significant cost and time risk to the State. The Program Director also noted that the initial cost claims were substantially higher than expected and the PPP Contract Administration team were working with Project Co to resolve issues as they arose and identifying ways to complete the modifications as soon as possible.

Our review of information provided to the Committee noted that for a number of the bundles the scope, timing and cost of project modifications had not been agreed with Project Co. Further, a number of the items were considered as an extreme risk. This was consistent with the observation made by the independent firm engaged to undertake an ongoing review of the achievability of the MWP. In June 2015 the firm reported that State works modifications had not been formally agreed with Project Co and included in the MWP.

Risk exposure

Uncertainty regarding the scope, timing and cost of modifications required to install equipment may result in delays in the MWP and associated delay costs.

Recommendations

We recommended SA Health agree the scope, timing and cost of modifications with Project Co as soon as practical and ensure the revised installation time frames are reflected in the MWP.

Response

SA Health advised that the Project Director had issued notices to Project Co requiring information on the cost and timing of modification works, as a result of State selection of clinical equipment. SA Health advised that the objective of this was to have agreed outcomes reflected in the MWP by the end of September 2015.

We understand that the Deed executed between the Minister for Health and Project Co on 17 September 2015 may have addressed this risk. For instance, we understand that by executing the Deed, the risks related to project modifications and extension of time implications have been crystallised and settled with Project Co. That is, in exchange for agreeing to pay Project Co a negotiated amount, Project Co has released the State from claims including extension of time/delay costs for specific modifications including fixed clinical equipment.

The full implications of the specific clauses contained in the Deed on the project, including the extent to which the Deed addresses this matter will be reviewed in the next phase of our review.

6.7.6 Strategic acquisition planning – new Royal Adelaide Hospital ICT Program

Our review of the procurement arrangements established for the new RAH ICT Program found that a strategic acquisition plan was not prepared for ICT services procured for the new RAH ICT project. We noted that a detailed acquisition plan was developed and approved by the SPB. The plan indicated that the procurement project, which had an estimated cost of $40 million, was to be completed in stages.

The first stage (valued at approximately $496 000) was to scope, define, cost and document an integrated program of ICT works for the new RAH and the second stage was to manage the implementation of the ICT Program. The stage was awarded to a contractor who completed the scope of works in January 2015. However, after an analysis of the potential market, a decision was made not to proceed with the second stage as it was considered that the resources were insufficient and the risks were too great to contract out large aspects of delivering the ICT Program. We noted that an alternative strategy was developed to deliver the strategy.

The revised strategy represents a significant departure from the approach detailed in the initial detailed acquisition plan approved in July 2014. The shift from procuring and contracting out works to a single contractor to procuring resources for specific roles and discrete work packages presents a different risk profile and complexities associated with managing the procurement project.

We found the risk assessment and analysis of the changed approach for stage two was not documented. In addition, it was not clear who approved the decision not to proceed with stage two as detailed in the detailed acquisition plan approved by the SPB.

Further, given the size, revised approach and importance of the procurement process to the new RAH project, we consider that it was appropriate for SA Health to develop a strategic

acquisition plan to document the procurement approach and address key aspects of the procurement arrangements including:

- background, procurement context and strategy
- specific items/works to be procured
- project resourcing
- approvals and delegations
- the procurement strategy
- project timeliness
- procurement budget and estimated contract values
- probity
- risks and treatment strategies
- evaluation criteria and methodology
- procurement project governance and reporting
- contract establishment and management.

We considered that developing a strategic acquisition plan would assist in ensuring a consistent approach in procuring the ICT services, enhance transparency and assist in ensuring the efficient and effective use of resources.

The matter was raised with SA Health, who subsequently commenced developing a draft strategic acquisition plan for delivering the ICT services for the new RAH project.

Risk exposure

Ineffective or inefficient procurement of ICT services for the new RAH project.

Decisions to significantly change the approved procurement approach may not be appropriately documented and supported by robust risk assessment and analysis.

Recommendations

We recommended SA Health finalise and approve the draft strategic acquisition plan for the procurement of ICT services for the new RAH project.

Further, we recommended SA Health ensure the approval to revise the approved procurement approach for major procurements and the risk assessment and analysis performed to support the revised approach are appropriately documented.

Response

SA Health advised that the ICT strategic acquisition plan has been drafted and will be finalised in October 2015 once the ICT budget and cost pressures are resolved with the Committee.

6.7.7 Management of procurements – new Royal Adelaide Hospital ICT Program

The procurement of ICT services for the new RAH project is significant given the number procurements, complexity and total value (originally estimated at $40 million). Our review of

ICT services procurement for the new RAH project identified a number of areas requiring improvement and attention including the following:

- there was no consolidated record of the nature, value and status of procurements for the new RAH ICT Program. At the time of our review the new RAH Procurement work stream was in the process of updating the Procurement Contract Management System with details of ICT procurements

- there was a lack of a robust process to manage and track ICT procurements through the various stages of the procurement lifecycle. We found that the new RAH ICT work stream was in the process of developing the JIRA system (ie a tracking tool) to manage procurements and track the status through to completion

- no reporting was provided to the Committee or senior management on the progress of procurement arrangements for the new RAH ICT Program.

Risk exposure

The procurement of ICT services for the new RAH project may not be managed effectively or efficiently.

Recommendations

We recommended SA Health:

- update all new RAH ICT procurements to the Procurement Contract Management System as a matter of urgency

- finalise the development and implementation of the JIRA system and related procedures to assist with managing and tracking ICT procurements through the various stages of the procurement lifecycle

- develop and implement regular monitoring and reporting to the Committee and senior management on the status of the procurement of ICT services for the new RAH project.

Response

SA Health responded to the matters raised and indicated:

- work was underway to consolidate ICT procurements in the Procurement Contract Management System with the process expected to be completed by the end of October 2015

- the implementation of JIRA is complete and the related procedures are currently being finalised and implemented

- a register of procurements and the current status will be implemented and provided to the Committee.

7 Key challenges and recommendations

7.1 Introduction

The new RAH project represents a significant project for the State in terms of the resources allocated to deliver the project and its intended benefits in providing enhanced and sustainable health care services and outcomes to the public of South Australia.

Our review noted a number of challenges which need to be addressed and managed to ensure the project is successfully delivered. Many of these matters are monitored and subject to oversight by SA Health and governance committees established to oversee the project. The following commentary provides a summary of some of the key challenges requiring ongoing focus and management attention and related recommendations.

7.2 Transitional and operational readiness planning

As previously highlighted, the project is progressing through a critical phase of the project lifecycle as it transitions through the design and construction phase to operational commissioning and the transition of services from the existing hospital to the new hospital.

The new RAH project is a large, multifaceted and complex project that presents a number of challenges and risks including:

- the delivery and integration of new health enterprise ICT systems, some of which have yet to be fully developed, tested and implemented across the rest of the public health system
- the use and integration of innovation, new technology and ways of doing things
- continuing operations throughout the development of the project and the move to the new hospital facilities
- delivering such a large and complex project in parallel to substantial health reform initiatives (ie Transforming Health)
- ensuring staff are ready, appropriately trained and embrace the required changes and related reform initiatives positively
- financial management of finite resources to deliver the project and realise the expected benefits
- the coordination and integration of the services provided by Project Co under the PPP arrangements with services (ie clinical and other support services) to be provided the State.

The successful transition from the existing hospital to the new hospital, will require effective transitional and operational readiness planning and management oversight. Although, not specifically reviewed as part of this phase of our review process, we noted that reports and advice provided to the Committee indicates that further attention needs to be given to developing detailed operational planning and the need to complete a range of service delivery plans.

We recommend that SA Health give ongoing focus to completing detailed transitional and readiness planning and the outstanding delivery plans.

7.3 Business planning and Transforming Health reform initiatives

The State Government has released a major health reform initiative, Transforming Health, to improve the consistency and quality of care across South Australia's health system. The reform initiative involves:

- the State's health services working differently and in partnership
- focussing on evidence-based, state-wide models of care
- using different initiatives to unlock capacity and improve patient's access and use of metropolitan hospitals.

This significant reform initiative is being implemented in parallel to the implementation of the new RAH. We understand that this presents challenges to the new RAH Program as the details of some aspects of the reforms, such as the impact on service levels and activity on the new RAH, are being developed and finalised.

As highlighted previously, SA Health is continuing to progress work to complete the refreshed business case for the new RAH including finalising the model of care and staffing models. Further, we understand that work is continuing in reflecting the impact of the Transforming Health reforms on the business case, the model of care and staffing levels for the new RAH.

We recommend that SA Health continue to give focus to this activity and finalise and communicate the outcomes of this important work to relevant stakeholders as soon as possible.

7.4 Delivery of critical enterprise ICT systems

The delivery of the model of care for the new RAH is dependent on a number of enterprise-wide ICT systems including EPAS, ESMI, EPLIS and iPharmacy. The EPAS and ESMI systems were originally planned to be rolled out at the existing RAH prior to the move to the new RAH, however implementation problems and delays resulted in a decision being made to implement the systems directly at the new RAH.

Risk management information provided to governance committees overseeing the project have highlighted risks, assessed as either extreme or high, regarding implementing key health enterprise systems (ie EPAS, EPLIS, ESMI etc). Further, our review of the enterprise system implementation projects found a number of the projects have experienced problems and delays. The reviews identified risks and challenges in meeting revised functionality, implementation deadlines and budget targets, and noted that contingency systems and arrangements had not sufficiently progressed.

Addressing the risks will require close and ongoing monitoring and management of the systems by the system owners and the new RAH Program.

Further, it is noted that the risk assessments and mitigation strategies, implementation plans, and work schedules for each enterprise system will need to be revisited and revised to reflect the impact of the extension in completion dates (as specified in the Deed) and the delay in the hospital opening.

We recommend that SA Health update risk assessments and mitigation strategies and continue to monitor and report on the status of the projects and risk mitigation strategies on an ongoing basis.

7.5 Extension of contractual dates and delayed opening date

The PPP arrangements and the Project Agreement place significant contractual obligations on both the State and Project Co. In particular, the Project Agreement includes a large number of clauses and requires keys tasks to be completed within specified dates and time frames. The State and Project Co have agreed to extend the Date for Technical Completion and Commercial Acceptance by 76 days. Further, in order to avoid opening the new hospital during the winter flu season, the State has decided to open the new hospital by November 2016.

This will require SA Health to review the impact, including previous risk assessments, of extending the key contractual completion dates and deferring the opening of the hospital. The revised dates will provide additional time to complete some activities and may mitigate some previously identified risks. It is noted, however, that the revised contractual dates and delayed opening time will require a review of existing scheduling and implementation plans and may result in new risks such as:

- management of pre-existing contractual delivery/installation dates for equipment procurements
- increased equipment holding/storage costs
- warranty period implications for equipment
- budgetary cost pressures due to additional project management and other implementation/transition costs
- opportunity for additional project scope creep and project variations
- lack of clarity regarding the contractual deadlines required to be performed under the agreement.

We recommend that SA Health give specific focus to reviewing the implications of the revised completion and hospital opening dates. Further, we recommend SA Health update risk assessment and mitigation strategies, program schedules and implementation plans as required.

7.6 Resolution of Facility Management Subcontractor claims

Under the PPP arrangements Project Co, through a subcontractor (Spotless), will provide facilities management services over the operating term of the Project Agreement. The State is required to complete State funded works in accordance with requirements of the Project Agreement.

It was noted, however, that the Deed did not release the State with respect to claims raised or to be raised by the Facility Management Subcontractor, for costs that Project Co is entitled to under the Project Agreement (other than delay costs) arising from modifications as specified in the Deed.

At the time of finalising this Report, we were advised the State was in the process of resolving matters relating to claims raised or to be raised by the Facility Management Subcontractor.

We recommend that the State work collaboratively with Project Co to resolve outstanding claims by the Facility Management Subcontractor, as soon as practical, to achieve the best outcome for the project and the State.

7.7 Outstanding independent consultant recommendations

As detailed in section 5.1, SA Health has engaged an independent consultant to undertake a number of governance reviews and a functional review of the new RAH Program. The consultant identified areas for improvement, made a number of recommendations and highlighted priority actions.

At the time of our review SA Health was in the process of addressing the matters and recommendations made by the consultant.

We recommend that SA Health continue to give ongoing focus to addressing the matters raised by the consultant and report the status of outstanding action items.

8 Timeline of key events

8.1 Summary of key events

Date	Event
April 2007	Cabinet noted the need to continue health reforms including changes to health service delivery and a capital investment strategy. Cabinet approved the construction of a new hospital to replace the existing RAH on railway land west of the Morphett Street Bridge and closure of the existing RAH following construction of the new hospital.
December 2007	Cabinet noted that the business case for the new hospital identified that a PPP was the preferred method of delivering the project and Cabinet approved the project being delivered as a PPP.
May 2009	The State Procurement Board, approved, subject to a number of conditions, the Acquisition Plan for the new RAH PPP project.
June 2009	Cabinet approved the release of an invitation for an Expression of Interest to the private sector for the delivery of the new RAH PPP project.
November 2009	The State announced a shortlist of Expression of Interest respondents who were assessed as capable of delivering the project.

Date	Event
December 2010	Cabinet approved the appointment of Project Co as the Preferred Proponent for the new RAH PPP project subject to the resolution of a number of outstanding matters.
May 2011	Cabinet noted that the total nominal construction cost of the new RAH PPP project was $2094.5 million comprising $1849.8 million for Project Co's total nominal construction cost and $244.7 million for State funded works. Cabinet also approved the Minister for Health executing a Project Agreement with Project Co for the delivery of the new RAH PPP project.
	The Project Agreement between the Minister for Health and Project Co was executed on 20 May 2011.
June 2011	Financial Close was achieved on 6 June 2011.
August 2012	Project Co gave notice of a claim for direct cost and extension of time for non known contamination remediation.
September 2012	Additional State works funding totalling $3.4 million for additional electrical supply infrastructure was approved by Cabinet.
October 2014	Cabined approved an additional $176.6 million for State works including transition costs to facilitate the successful transition from the existing RAH to the new RAH.
November 2014	Project Co submitted a claim for all outstanding contamination remediation including two components that had been agreed at a value of $457 000 in March 2014.
December 2014	The Project Director made a determination regarding Project Co's claim for all outstanding contamination remediation totalling $15 million.
April 2015	The State Operational Commissioning Plan was finalised and provided to Project Co.
May 2015	Project Co submitted an updated claim for all outstanding contamination remediation after withdrawing its dispute of the Project Director's December 2014 determination.
August 2015	The Project Director made a determination regarding Project Co's updated claim for all outstanding contamination remediation totalling $14.16 million.
September 2015	Cabinet approved the Minister for Health and Project Co to execute a Deed of Settlement and Release which revised certain contractual arrangements between the State and Project Co.
	The Deed of Settlement and Release between the Minister for Health (on behalf of the State) and Project Co was executed on 17 September 2015. The Deed settled all pre-December 2012 contamination claims (direct, prolongation and extension of time costs) made by Project Co.