ACT Government | ACT Health

Our reference: **FOI19/75**

[redacted]

Dear [redacted]

DECISION ON YOUR ACCESS APPLICATION

I refer to your rescoped application under section 30 of the *Freedom of Information Act 2016* (FOI Act) received by ACT Health Directorate (ACTHD) on Wednesday 29 January 2020.

This application requested access to:

"Documents related to a proposal to redevelop Buildings 2 and 3 of the Canberra Hospital from 2012 to 2015. In particular, I would like:

a) Documents that informed the development of this proposal and the eventual decision to not proceed with it;
b) Costings of this proposal;
c) Briefing documents prepared for the Minister for Health about this proposal;
d) Consultation with staff and other stakeholders about this proposal;
e) Documents of meetings related to this proposal including agenda and minutes. This does not include purely administrative documents such as booking a room for a meeting."

As confirmed by your Office, this is refined to corresponding records that are held within our official record management system and held by the Strategic Infrastructure Team in the ACT Health Directorate that did not form part of the response to FOI19/08 provided last year.

I am an Information Officer appointed by the Director-General of ACT Health Directorate (ACTHD) under section 18 of the FOI Act to deal with access applications made under Part 5 of the Act. ACTHD was required to provide a decision on your access application by **Thursday 19 March 2020**.

I have identified 24 documents holding the information within scope of your access application. These are outlined in the schedule of documents included at Attachment A to this decision letter.

Decisions
I have decided to:

- grant full access to 6 documents;
- grant partial access to 17 documents; and
- refuse access to 1 document.

My access decisions are detailed further in the following statement of reasons and the documents released to you are provided as Attachment B to this letter.

In reaching my access decision, I have taken the following into account:

- The FOI Act;
- The contents of the documents that fall within the scope of your request;
- The views of relevant third parties; and
- The *Human Rights Act 2004*.

Full Access
I have granted full access to 6 documents at reference 3, 6, 7, 10, 12 and 24.

Refuse Access
I have decided not to grant access to 1 document at reference 20. The information contained in this document is comprised of Cabinet information and I therefore considered contrary to the public interest to release, under Schedule 1, 1.6 (1) Cabinet Information.

Partial Access
I have granted partial access to 17 documents at reference 1, 2, 4, 5, 8, 9, 11, 13-19, 21-23.

Public Interest Factors Favouring Disclosure
The following factors were considered relevant in favour of the disclosure of the documents:

- Schedule 2.1 (a) (i) promote open discussion of public affairs and enhance the government's accountability;
- Schedule 2.1 (a) (iv) ensure effective oversight of expenditure of public funds.

Public Interest Factors Favouring Non-Disclosure
The following factors were considered relevant in favour of the non-disclosure of the documents:

- Schedule 1, 1.2 Information subject to legal professional privilege
- Schedule 1, 1.6 Cabinet Information.

- Schedule 2, 2.2 (a) (ii) prejudice the protection of an individual's right to privacy or any other right under the *Human Rights Act 2004;*
- Schedule 2, 2.2 (a) (xi) prejudice trade secrets, business affairs or research of an agency or person;
- Schedule 2, 2.2(a) (xiii) prejudice the competitive commercial activities of an agency.

The information contained in document at references 1, 9 and 22 is comprised of legal information and I therefore considered contrary to the public interest to release, under Schedule 1, 1.2 Information subject to legal professional privilege.

The information contained in documents at references 2, 5, 14, 18 and 20-23 is comprised of Cabinet information and I therefore considered contrary to the public interest to release, under Schedule 1, 1.6 Cabinet information.

Documents at references 2, 4, 5, 8, 9, 11, 13-17, 19, 21-23 contain deletions to information that I consider, on balance, to be contrary to the public interest to disclose under the test set out in section 17 of the Act. The information contained at these references is personal information including signatures and mobile numbers of government and non-government employees, information relating to a procurement process and business affairs of non-government organisations.

Additionally, document at reference 22 contains information that is out of scope of your request.

Charges
Processing charges are not applicable to this request.

Disclosure Log
Under section 28 of the FOI Act, ACTHD maintains an online record of access applications called a disclosure log. The scope of your access application, my decision and documents released to you will be published in the disclosure log not less than three days but not more than 10 days after the date of this decision. Your personal contact details will not be published.

https://www.health.act.gov.au/about-our-health-system/freedom-information/disclosure-log.

Ombudsman review
My decision on your access request is a reviewable decision as identified in Schedule 3 of the FOI Act. You have the right to seek Ombudsman review of this outcome under section 73 of the Act within 20 working days from the day that my decision is published in ACT Health's disclosure log, or a longer period allowed by the Ombudsman.

If you wish to request a review of my decision you may write to the Ombudsman at:

The ACT Ombudsman
GPO Box 442
CANBERRA ACT 2601
Via email: ACTFOI@ombudsman.gov.au
Website: ombudsman.act.gov.au

ACT Civil and Administrative Tribunal (ACAT) review
Under section 84 of the Act, if a decision is made under section 82(1) on an Ombudsman review, you may apply to the ACAT for review of the Ombudsman decision. Further information may be obtained from the ACAT at:

ACT Civil and Administrative Tribunal
Level 4, 1 Moore St
GPO Box 370
Canberra City ACT 2601
Telephone: (02) 6207 1740
http://www.acat.act.gov.au/

Further assistance
Should you have any queries in relation to your request, please do not hesitate to contact the FOI Coordinator on (02) 5124 9831 or email HealthFOI@act.gov.au.

Yours sincerely

Liz Lopa
Executive Group Manager
Strategic Infrastructure

19 March 2020

ACT Government | ACT Health

FREEDOM OF INFORMATION SCHEDULE OF DOCUMENTS

Please be aware that under the *Freedom of Information Act 2016*, some of the information provided to you will be released to the public through the ACT Government's Open Access Scheme. The Open Access release status column of the table below indicates what documents are intended for release online through open access.

Personal information or business affairs information will not be made available under this policy. If you think the content of your request would contain such information, please inform the contact officer immediately.

Information about what is published on open access is available online at: http://www.health.act.gov.au/public-information/consumers/freedom-information

APPLICANT NAME	WHAT ARE THE PARAMETERS OF THE REQUEST	FILE NUMBER
[redacted]	*"Documents related to a proposal to redevelop Buildings 2 and 3 of the Canberra Hospital from 2012 to 2015. In particular, I would like:* *a) Documents that informed the development of this proposal and the eventual decision to not proceed with it;* *b) Costings of this proposal;* *c) Briefing documents prepared for the Minister for Health about this proposal;* *d) Consultation with staff and other stakeholders about this proposal;* *e) Documents of meetings related to this proposal including agenda and minutes. This does not include purely administrative documents such as booking a room for a meeting."*	**FOI19/75**

Ref Number	Page Number	Description	Date	Status Decision	Factor	Open Access release status
1.	1-2	Email: FW: HIP/CADP- Building 3, 2	09/02/2012	Partial release	Schedule 1, 1.2 Information subject to legal professional privilege	Yes

2.	3-39	THINC Project Director's Recommendation (PDR)	11/07/2012 26/07/2012	Partial release	Schedule 2, 2.2(a)(xi) prejudice trade secrets, business affairs or research of an agency or person; Schedule 2, 2.2 (a)(ii) prejudice the protection of an individual's right to privacy or any other right under the *Human Rights Act 2004;* Schedule 1, 1.6 Cabinet information	Yes
3.	40-41	Minute: Advice on PDR 73: Building 3, 2 Requirement for Technical Review Consultants	03/09/2012	Full release		Yes
4.	42-44	Minute: Advice on PDR 82: Building 3,2 Project Governance: Brief Verification and Design Phases	03/09/2012	Partial release	Schedule 2, 2.2 (a)(ii)	Yes
5.	45-51	HIP Project Request: Commercial Advisor Engagement to Support Building 3/2 Delivery Model Analysis	03/10/2012	Partial release	Schedule 2, 2.2 (a)(ii) Schedule 1, 1.6	Yes
6.	52-63	Minute: Building 3 & 2 Project Management Framework	19/10/2012	Full release		Yes
7.	64-71	Minute: Canberra Hospital Emergency Department Treatment Spaces- Health Infrastructure Program New Building 3 Health Planning Unit Brief, Request for Additional Information	15/01/2013	Full release		Yes
8.	72-74	HIP Project Request: Termination of Principal Consultant (PC) procurement process for Building 3, 2 & Associated Works project	08/05/2013	Partial release	Schedule 2, 2.2 (a)(ii)	Yes

9.	75-79	Email: FW: RFT 18158.110 Principal Consultant with attachment	20/05/2013	Partial release	Schedule 2, 2.2 (a)(xiii) Prejudice the competitive commercial activities of an agency; Schedule 1, 1.2	Yes
10.	80-81	Minute: Project Director Start up Services- Building 2/3 Forward Design and Building 1, 10 and 12	11/12/2013	Full release		Yes
11.	82	Email: FW: Additional scope of work Justin Barrett	05/03/2014	Partial release	Schedule 2, 2.2 (a)(ii)	Yes
12.	83-84	Minute: Building 3 and 2 Investment Logic Workshop	08/04/2014	Full release		Yes
13.	85-126	Minute: Project Director, Health Infrastructure Program (HIP): Project Director for Clinical Unit Redevelopment Projects at the Canberra Hospital Selection and Engagement; Project Director Start up Services- Building 2/3 Forward Design and Building 1, 10 and 12 Audits- Contract Variation	05/05/2014	Partial release	Schedule 2, 2.2 (a)(ii)	Yes
14.	127-131	Correspondence Clearance: Single Select Procurement for Commercial Advisor Services for the completion of Building 3/2 Business Case including Minute	23/12/2014	Partial release	Schedule 2, 2.2 (a)(ii) Schedule 1, 1.6	Yes
15.	132-162	KPMG letter- Business Case for Phase 1 of the Redevelopment of Canberra Hospital (Buildings 3 and 2)	22/12/2014	Partial release	Schedule 2, 2.2(a)(xi) Schedule 2, 2.2(a)(xiii) Schedule 2, 2.2 (a)(ii)	Yes
16.	163-171	Minute: Tender Evaluation Report for Commercial Advisory Services and the delivery of a Business Case for the Building 2 and 3 Redevelopment Project with attachment: Tender Evaluation Report	23/01/2015	Partial release	Schedule 2, 2.2 (a)(ii) Schedule 2, 2.2(a)(xiii)	Yes

17.	172-180	Minute: Commercial Advisor Services for the completion of Building 3/2 Business Case- Director-General Approval for Confidential Text	17/02/2015	Partial release	Schedule 2, 2.2 (a)(ii)	Yes
18.	181-188	Ministerial Brief: Canberra Hospital Building 2/3 Redevelopment- Procurement Model Comparison	February 2015	Partial release	Schedule 1, 1.6	Yes
19.	189-190	Minute: Procurement Plan Variation for Commercial Advisory Services and the delivery of a Business Case for the Building 2 and 3 Redevelopment Project With attachments at reference 19	20/04/2015	Partial release	Schedule 2, 2.2 (a)(ii)	Yes
20.	191	Building 3, 2 Funding Requests	N/A	Not for release	Schedule 1, 1.6	Yes
21.	192-396	Correspondence Clearance: ministerial Brief- Status of Building 2-3- Redevelopment Business Case including KPMG Draft Business Case	March 2015	Partial release	Schedule 2, 2.2 (a)(ii) Schedule 1, 1.6	Yes
22.	397-421	Correspondence Clearance: Ministerial Brief- Benefits of Building 2-3 Redevelopment progressing to 30 percent Preliminary Sketch Plan stage with Attachments A and B <u>Page 406 - 414 Attachment A:</u> Correspondence Clearance: Options for Developing Clinical Services Buildings at the Canberra Hospital under the Health Infrastructure Program- Continuity of Service B32 schedule final <u>Page 415 – 421 Attachment B:</u> Ministerial Brief MIN13/628	May 2015	Partial release	Schedule 2, 2.2 (a)(ii) Schedule 1, 1.6 Out of scope Schedule 1, 1.2	Yes

23.	422-424	Minute: Location of Interventional Cardiology in New Building 3/2	19/05/2015	Partial release	Schedule 1, 1.6	Yes
24.	425-427	Select Committee on Estimates 2015-2016 Budget: Canberra Hospital- New Clinical Services Buildings (Buildings 2 and 3)	17/06/2015	Full release		Yes
Total Number of Documents						
24.						

1

Email Message

From:	Brown, Peggy [EX:/O=ACTGOV/OU=CALLAM/CN=RECIPIENTS/CN=PEGGY_BROWN]
To:	Elsey, Jennifer [EX:/O=ACTGOV/OU=CALLAM/cn=Community Care/cn=Jennifer_Elsey]
Cc:	
Sent:	09/02/2012 at 9:20 PM
Received:	09/02/2012 at 9:20 PM
Subject:	FW: HIP/CADP - Building 3, 2

T/R

Dr Peggy Brown MBBS (Hons), FRANZCP
Director- General

[redacted]

>
>Dr Loretta M. Zamprogno
>Deputy Chief Solicitor
>ACT Government Solicitor
>tel (02) 620 70653
>fax (02) 620 70539

>email: loretta.zamprogno@act.gov.au
>
>Our Reference: 620798
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>

CGR12/7677

ADVICE / ACTION

ACT Government Health

THINC HEALTH

PROJECT DIRECTOR'S RECOMMENDATION (PDR) (HIP_PDR_79)

Project:	Building 3, 2	**Project No.:**	
From:	Saurabh Bhandari	**File Ref.:**	
Date:	11 July 2012	**No. pages including this:**	
Requested by:		**Aconex Ref:**	

To	cc	Name	Organisation	Fax No./Email/By Hand
☐		Adrian Scott	RDU	Aconex / By Hand
	☐	Grace Burton	RDU	Aconex
	☐	Susan Patton	THA	Aconex
	☐	Ben Mackey	THA	Aconex
	☐	Natasha Richens	THA	Aconex

SUBJECT: Building 3, 2 & Associated Works – Project Scope Briefing

1.0 Executive Summary

The Building 3, 2 & Associated Works project is due to commence with a Principal Consultant (PC) in July/Aug 2012.

The key stakeholders and designers, including:

- Project Management Team (RDU, HSPU and PD)
- Executive Directors & Health Leaders
- End users & Stakeholders
- Principal Consultant team

Require to be briefed about the current understanding of the process and design brief for the buildings 3, 2 and associated projects, in order to be sufficiently informed prior to the commencement of the design process. This formal briefing will allow the teams to act more decisively, upon understanding the bigger picture of the proposed works.

The Briefing shall be undertaken by both the members of HSPU, Project Directors as well as the Health Advisory team from Thinc Health Australia, who were part of the team which put together PDP documents and have since been involved in other modifications to the scope documents,

This PDR seeks approval of the scope & strategy, of this briefing work, along with the associated estimated costs of [redacted] for 23 consultant days.
**(Panel rates for Specialist Health Planning Services Panel have been assumed.)*

2.0 Background

The Canberra Hospital Building 3, 2 & Associated Works development will require detailed planning to ensure that optimal facility outcomes are delivered to support health care. The Principal Consultant (PC) will be appointed during July/ August 2012, in the lead up to this the Health Directorate will need to ensure that it has the capacity and resources available to inform and support the design process.

The Building 3, 2 & Associated Works development is a huge project and the associated scope is complex. Earlier planning stages have provided good definition of the project scope. The Health Planning Unit (HPU) briefs and associated schedules of accommodation (SoA) have recently been reviewed by the Health Directorate and with a few small exceptions, the content remains current.

In the lead up to the appointment of the PC, consideration is required to be given to briefing requirements for the project, as successful management of projects is only possible when the key stakeholders have a clear and detailed understanding of the project scope.

It is therefore recommended, that the Health Directorate use the next four to eight weeks to develop a framework and provide a structured briefing and education process so that the teams understand the project scope and ensure that other structures are in place to support the project.

3.0 Methodology

It is recommended that a series of sessions are conducted during the lead up to the appointment of the PC. These sessions ideally should be completed prior to the commencement of the design stages. These sessions would be structured according to the target audience.

A series of sessions are therefore proposed and should be presented by Jenny Green and Maria Fahey from THA, in conjunction with HSPU internal teams. A structured process will ensure the following groups are prepared for the commencement of the design stage.

1. Project Management Team (RDU, HSPU,SSICT, SSP and PD)
2. Executive Directors & Health Leaders
3. End users & Stakeholders
4. Principal Consultant team

Briefing project teams

The first series of meetings would brief the project team (RDU, HSPU, SSICT, SSP & Project Directors) at a whole of facility level and then at an individual HPU level. Two half-day sessions are suggested and these will cover:

- The Canberra Hospital Concept Design
- The Canberra Hospital Concept Design Implementation (Building 3, 2 & Associated Works scope)
- Major deliverables of the Building 3, 2 & Associated Works project
- Overview of all HPU briefs and associated space
- Status of planning (i.e. update on the list of issues developed by Thinc Health and HSPU)
- Risks (e.g. unresolved issues etc)

Briefing Executive Directors and Health Leaders

The second next series of meetings would be focused on briefing Executive Directors and others who are responsible for leading design groups. The presentations would be tailored to a smaller audience and may even be conducted on an individual basis and with a similar content level to that of the first series meetings.

Briefing users & Stakeholders

The third series of meetings would be aimed at providing education to user groups to prepare them for the design stages. These sessions held on large group format would be focused on matters such as planning changes, project principles and givens, project timeframes and their commitment and responsibilities throughout the design phases.

Briefing the Principal Consultant

The aim of this phase would be provide a detailed briefing the Principal Consultant around the scope of the project including recent changes. Given the complexity of the project it will take the PC time to understand and fully comprehend the complexities of the project.

Key elements to be undertaken by the briefing team during this phase include:

Briefing the PC on the documentation developed to date during the Project Definition Phase (PDP) such as

- Project principles
- Models of care and service delivery
- Concept design and the interrelationships with other HIP program components
- Outcomes, challenges and opportunities to deliver a world class health care facility

In partnership with Health Services Planning Unit (HSPU), identify changes to since the completion of the PDP, such as

- Departures from the original concept design scheme
- Recent developments and refinements
- Outstanding project items and provide guidance and advice as to how these might be progressed, what past lessons have been learnt and should be acknowledge going forward
- Identify areas where the client is seeking innovation. This is particularly relevant around the Level 4 floor plate given the recent changes post PDP.
- Be available on an as required basis, to provide support.

4.0 Estimated Resource Requirements

The following tables outline the estimated number of consultant days required to provide briefings to each of the teams as detailed in sections 3.

The nominated team would include:

- Andrew Bott
- Jenny Green
- Maria Fahey

Preparatory Works Prior to Briefing.

Discipline/ Resource	Time	Rate $	Cost $
Preparatory Works			
Jenny Green	2 days	[redacted]	
Maria Fahey	3 days		
Total	**5 days**		

The project directors shall continue to assist in the preparatory works required for such briefings, as part of their implementation works.

Discipline/ Resource	Time	Rate	Cost
Briefing project teams		[redacted]	
Jenny Green	1 day		
Maria Fahey	1 day		
Briefing Executive Directors & Health Leaders			
Jenny Green	4 days		
Maria Fahey	4 days		
Briefing users & Stakeholders			
Jenny Green	2 days		
Maria Fahey	2 days		
Briefing the Principal Consultant			
Andrew Bott	1 day		
Jenny Green	2 days		
Maria Fahey	1 day		
Total	**18 days**		

The overall cost for this resourcing shall be [redacted]

.

	It is the project directors recommendation, that this is a reasonable investment in undertaking this exercise for the project teams to be brought up to speed with the project briefs, as successful management of projects is only possible when the key stakeholders have a clear and detailed understanding of the project scope
5.0	**Funding**
	The funding for the preferred option may be funded from the following sources 1. Enhancing Canberra Hospital Facilities (Design) - $41.0m
6.0	**Recommendation**
	It is recommended that the client approves 1. The requirement to undertake this briefing process, to bring the teams up to speed, 2. The Methodology for the briefing process 3. The funding for engagement of the external consultants from the appropriation for Fwd Design of the Enhancing Canberra Hopsital Facilities. 4. Issue a work order for the work to be done under the new Panel Agreement of Specialist Health Planning Services .

ADVICE / ACTION

ACT Government Health

THINC HEALTH

Recommendation Endorsement

Project Director Design		
[redacted]	SANDEEP DHANDHRI	11/07/2012
Signature	Name	Date

Principal Project Director		
[redacted]	ML JOSEPH	11/7/12
Signature	Name	Date

The Project Director issues this Recommendation on the basis of information provided to, or available to, the Project Director in the course of providing the services. Recommendation reflects information at a point in time and relies on the accuracy of input information from other parties.

Endorsed by Shared Services Procurement (where required by ACT Health Directorate)			
[redacted]	VLADAN MILIC		8/8/12
Signature	Name		Date
Supported / Not Supported		Noted with comments	

Comments: ON RECOMMENDATION:

1) VERY GOOD IDEA - SUPPORTED IN PRINCIPLE

2) AS ABOVE

3) NOTED, VARIATION TO PD (BY PD) PROPOSED, WOULD NEW PANEL PROVIDE BETTER VFM? COULD THIS BE DONE UNDER THE EXISTING CONTRACT? (BEN MAKEY COULD PROVIDE BRIEFINGS?)

4) NOTED

GENERAL COMMENTS

3.0 METHODOLOGY - NO NEED TO PROVIDE BRIEFING TO PD?

BRIEFING THE PRINCIPAL CONSULTANT - WE NOTE REFERENCE TO 'RECENT CHANGES', THESE NEED TO BE IDENTIFIED AND PERHAPS NEGOTIATED WITH THE PREFERRED CONSULTANT FOR B32 PRIOR TO ENTERING IN CONTRACT (CONTRACT AWARD).

ACT Government Health

ADVICE / ACTION

THINC HEALTH

ACT Health Directorate Endorsement					
Redevelopment Unit Project Manager					
Supported / Not Supported		Noted with comments		Please discuss	
N/A				...../...../.....	
Signature		Name		Date	
Comments / Conditions:					
Director Redevelopment Unit					
Supported / Not Supported		Noted with comments		Please discuss	
[redacted]		ADRIAN SCOTT		2/8/12	
Signature		Name		Date	
Comments / Conditions:					
Executive Director Services and Capital Planning					
Approved / Not Approved		Noted with comments		Please discuss	
				...../...../.....	
Name		Signature		Date	
Comments / Conditions:					

CORR/8309

ACT Government Health

ADVICE+ACTION

THINC HEALTH

PROJECT DIRECTOR'S RECOMMENDATION (PDR) **(HIP_PDR_82)**

Project:	Building 3, 2	**Project No.:**	Building 3,2
From:	Saurabh Bhandari	**File Ref.:**	Pdr 82_ Building 3,2 Governance Structure & Resourcing
Date:	26/07/2012	**No. pages including this: 8**	
Requested by:	ACTHD	**Aconex Ref:**	

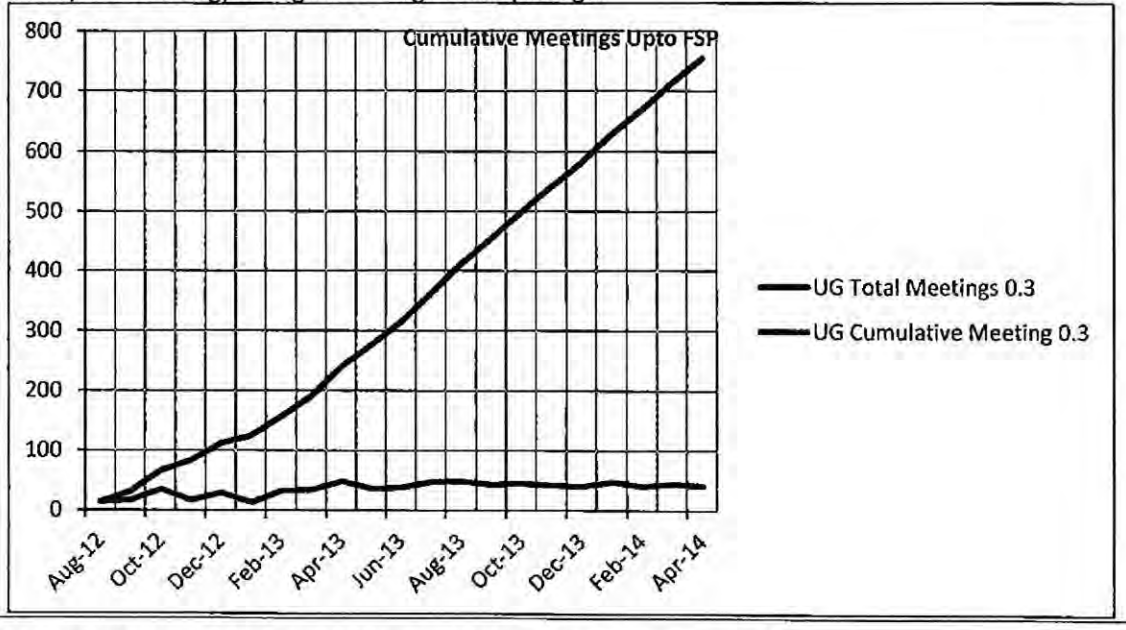
To	cc	Name	Organisation	Fax No./Email/By Hand
☐		Adrian Scott	RDU	Aconex / By Hand
	☐	Grace Burton	RDU	Aconex
		Jacinta George	ACTHD	Aconex
	☐	Susan Patton	THA	Aconex
	☐	Ben Mackey	THA	Aconex
	☐	Natasha Richens	THA	Aconex

SUBJECT: Building 3, 2 & Associated Works –Client side Project Governance & Resourcing

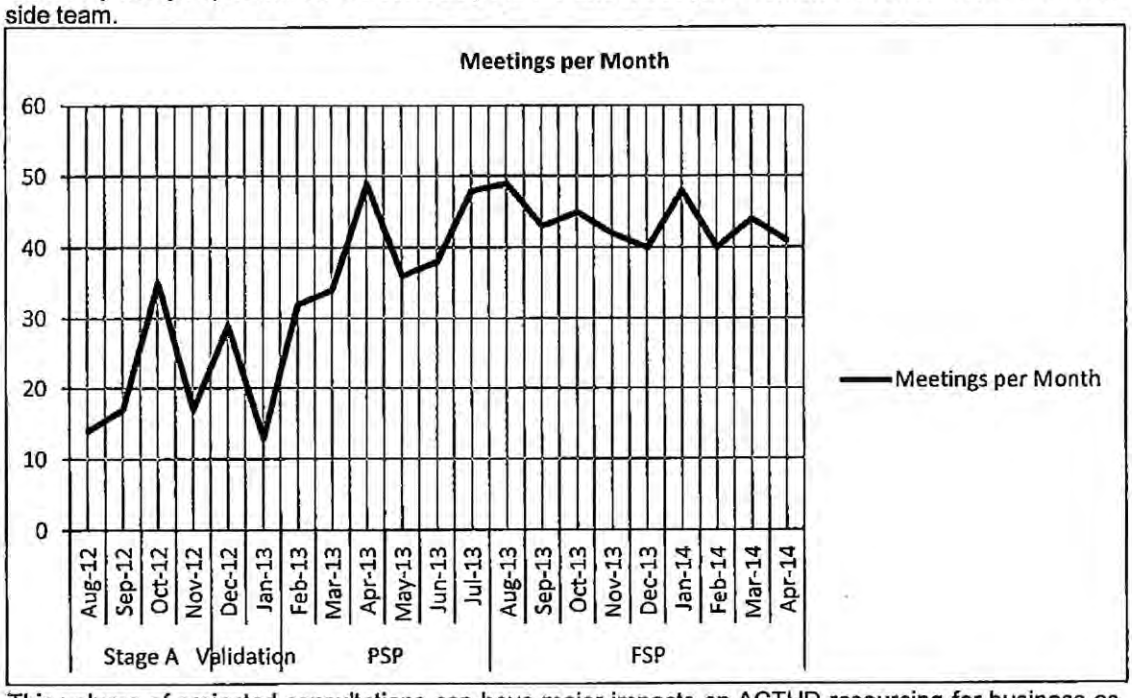
1.0 Executive Summary

Building 3, 2 Project on the HIP campus, is due to commence design in August 2012. The project will bring together Gross floor Area (GFA), of over 91,000 sqm, with construction cost exceeding [redacted] The average floor plate is in excess of 4000 sqm at plinth level and can contain up to 5 different departments. In order to work with the PC, for the design and the PSP / FSP level works; over 700+ meetings *(Attachment 1)* will be required in a period till April 2014.

At least 300 of these meetings will be required between now and end of PSP stage in June 2013. At least 60 of these key consultations/meetings/workshops with the PC's will be in the first 3 months of the PC's engagement, with further work required at the Health Directorate internal level to carry key users, HOD's along, through the design concept stage.



This is a critical stage and will require participation from strategic clinical leaders. It is anticipated that a monthly design cycle will be conducted by the PC and will require intensive involvement of the client side team.



This volume of projected consultations can have major impacts on ACTHD resourcing for business as usual and hence a governance strategy has been developed to minimize the impact of the design cycles on the ACTHD staff. This strategy is an outcome of discussions between the; Project Director, ACTHD, HSPU for the implementation of the works.

This PDR is a looking to gain approval to adopt and develop the Governance document

- *Project Governance – Client Side Structure | Version 1.0 | 11 July 2012.*

And provide ACTHD a projected Key resource requirement to run these consultations through the Building 3, 2 design process.

2.0 Background

The building 3, 2 projects are currently consolidated into HPU briefs for of 23 separate departments which include multiple craft level groups within themselves. During the various design and consultation stages, the PC will require a varying degree of interface with the end users to deliver a high quality health care facility.

In order to manage this complex of interface and ensuring a credible project audit, it will be essential to manage and maintain the information flow to the designers through a formal governance and client instruction procedure.

Given the scale of the project, and a very high degree of inter-operability required between the various departments, with synchronous workflows, it is recommended that a formal hierarchy is put in place for the management of the workflows, while minimizing repetitive and insular groupings.

The requirement to organize the project will be captured in the Principal Consultants (PC) Design Consultants Activity Plan (DCAP); which is likely to demand significant inputs from all of ACTHD stakeholders, to suit the PC's timeline for the design process.

Without a client side governance structure which is specific to the scale of the building 3,2 project, the PC's DCAP is likely to impose significant time pressures on ACTHD staff . Therefore, it is prudent to advice the PC of the ACTHD internal team organization, so that DCAP can be tailored to suit the availability of key personnel and decision lines; within the HIP governance procedures. The Project Directors have prepared a prelimnary analysis of the:

- Scheduled Meetings and TimeLine for recurrence
- Scheduled meeting and Attendees required.

This has been iteratively reprogrammed to reduce the ***'Individual commitment'*** of ACTHD personnel during the process.

3.0 Governance Strategy

This proposal looks to organize the ACTHD team in a manner so as to limit the resource pressures on individual personnel working for the HD, while still allowing the client the benefit of optimum and involved consultation through the design and implementation process.

In order to maximize efficiency of the user participation, it is suggested that specific meetings should be held for individual skill streams on strictly defined agendas, so that adequate and relevant participation is ensured.

An end of session and end of day catch-up will be run as part of the design management process to ensure coordination between disciplines; to minimise repetitive or inefficient utilization of ACTHD staff. The details of this process shall be developed further during the finalization of the DCAP of the design team and is not covered by the scope of this PDR.

A proposal documenting the detailed description of these governance structures and their responsibilities is attached for approval. (Project Governance – Client Side Structure | Version 1.0 | 11 July 2012).

This is generally based on the ACTHD Governance Plan for the HIP projects (Project Governance And Committee Structure | Version 3.0 | 25 February 2009). Specific detail has been added to existing governance structures through defined terms of reference for each group.

Further TOR will be developed for the Sub groups as and when the specific agendas of these groups are clarified through its members.

Table 1 Proposed Client Side Governance Hierarchy

Roles	Governance Hierarchy
Approval Body:	Redevelopment Committee
Endorsement Body:	Project Control Group (HIP)
Recommending Body:	**Executive Reference Groups**
Project Level Recommendation	Project Executive Reference Group (pERG)
Clinical/Non Clinical Recommendation	Executive Reference Group (ERG)
Craft Level Recommendation	Services User Group (SUG)
Recommending Body:	User Groups

4.0 Estimated Resourcing

The consultation exercise for the project will generally operate on an average of monthly cycle, over the next 18 months of design to FSP. This will ideally include short bursts of intensive user group interface followed by regular interface for project level requirements.

A tentative calendar of meetings & membership schedule has been developed by the Project

Directors/ HSPU to inform the schedule of project requirements. Based on the engagement cycles and comparison with similar projects the following resourcing levels are anticipated for the project up to FSP.

The following charts have been developed to provide an idea of the projected resource requirements during consultation for design of building 3, 2.

Figure 1 Typical Resource Commitment - Key Staff

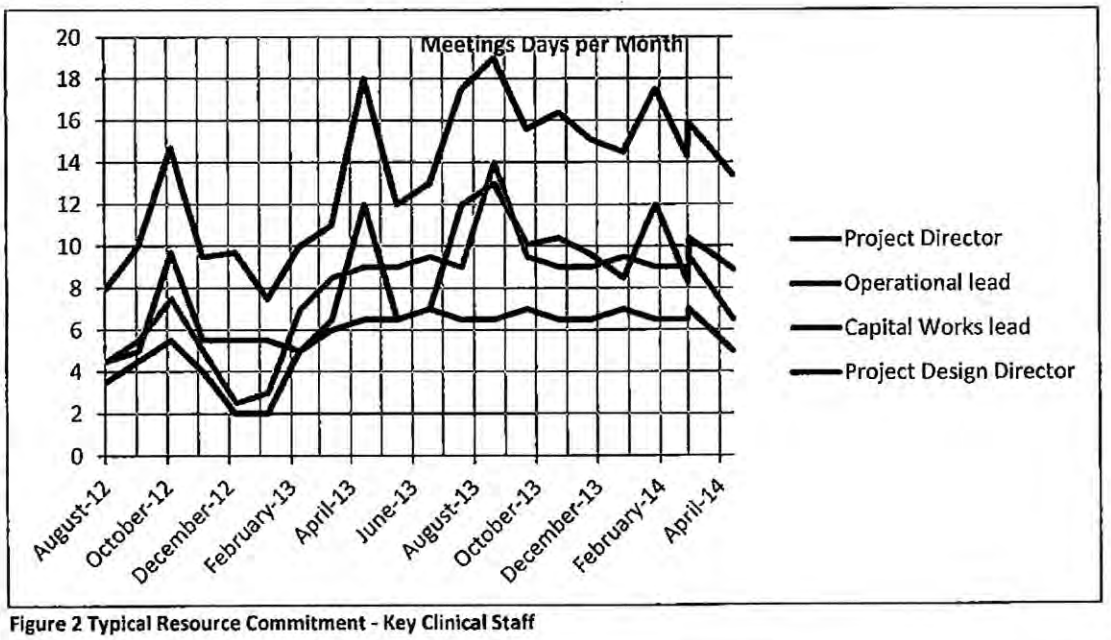


Figure 2 Typical Resource Commitment - Key Clinical Staff

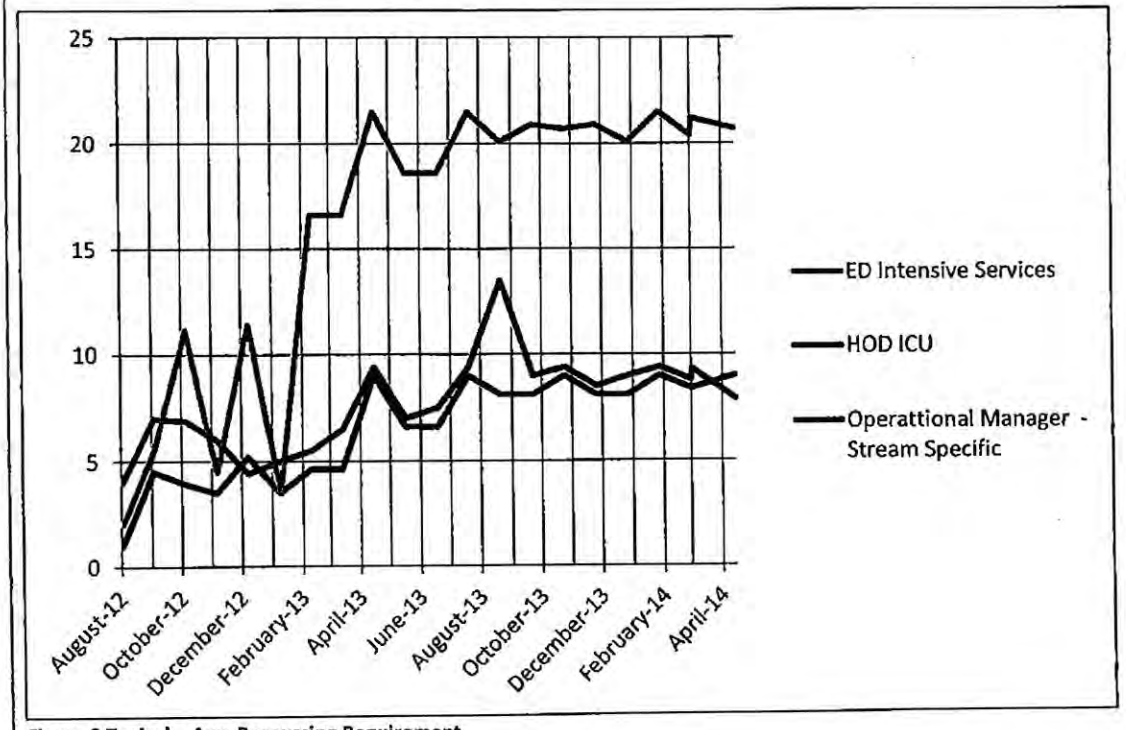
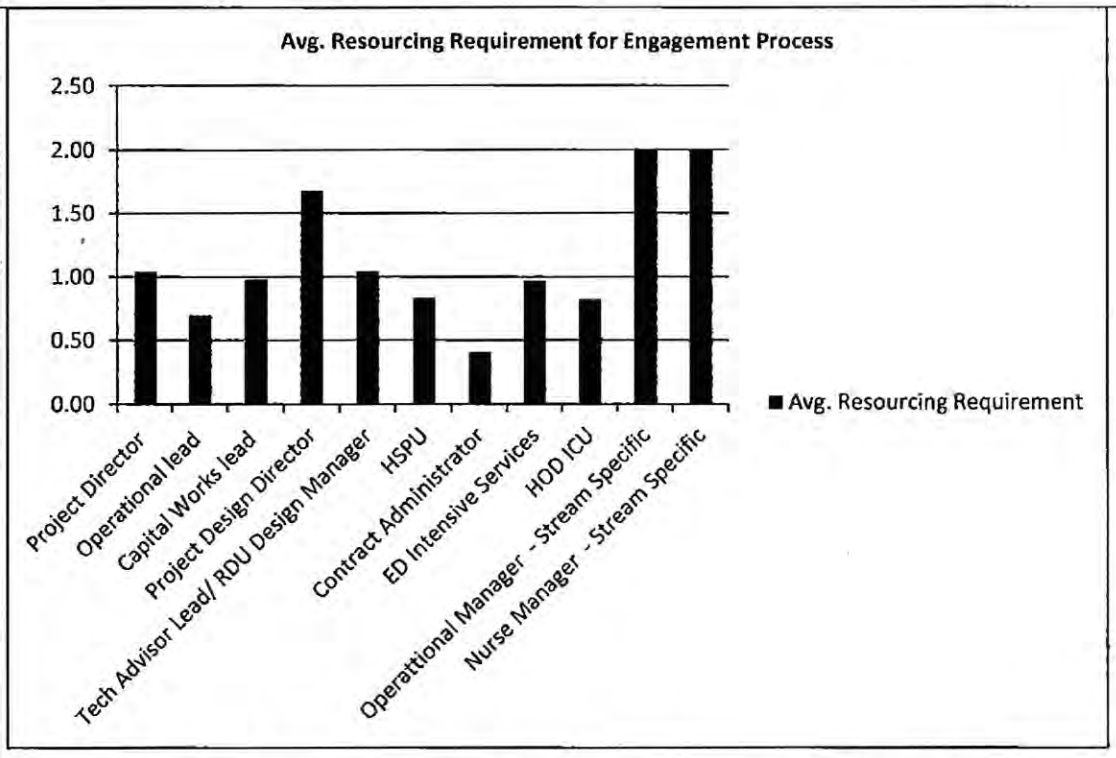


Figure 3 Typical - Avg. Resourcing Requirement



Resource quality: it is understood that the projected resource requirements will put enormous pressures on the ACTHD staffing and delegated representatives may be required to cover some of these positions and some of the roles will require multiple staff being allocated to cover specific positions.

In order for the engagement process to be successful; the representatives in these key positions should be suitably empowered on RACI* criteria and continuity of their services ensured, if they are filling in any of these above roles.
**RACI: Responsible, Accountable, Controlled, and Informed.*

These resourcing projections will need to be developed further in sync with the ACTHD/ HSPU/Principal Consultant (upon their appointment):

5.0 Recommendation

Project Governance

1. It is recommended that the governance strategy ***(Project Governance – Client Side Structure | Version 1.0 | 11 July 2012)*** is adopted by ACTHD; for further development.
2. Key individuals (leads) or representatives identified as Chairs for various groups
3. ACTHD instructs Key leads – to identify members of staff who will be participating in the planning process.

Resourcing

1. It is recommended that a Workshop is organized with ACTHD/HSPU/ RDU/ EDs; to clarify
   a. Roles and responsibility of staff
   b. Roles which are to be delegated
   c. Roles which will be shared
2. It is recommended that ACTHD develop a strategy to redistribute, day job workload of leads redistributed or delegates identified for individual roles.

6.0 Attachments

1. Project Governance – Client Side Structure | Version 1.0 | 11 July 2012
2. Project Governance and Committee Structure | Version 3.0 | 25 February 2009
3. Typical Meeting Schedule_Meeting Occurrences Commitment
4. Meeting Schedule_Meeting Time per month

ACT Government Health

ADVICE+ACTION

THINC HEALTH

Recommendation Endorsement

Project Director Design

[redacted] | SAURABH S BHANDARI | 27/7/2012

Signature | Name | Date

Principal Project Director

[redacted] | Susan Patton | 27/7/2012

Signature | Name | Date

The Project Director issues this Recommendation on the basis of information provided to, or available to, the Project Director in the course of providing the services. Recommendation reflects information at a point in time and relies on the accuracy of input information from other parties.

Endorsed by Shared Services Procurement (where required by ACT Health Directorate)

[redacted] | VLADAN MILIC | 10/8/12

Signature | Name | Date

Supported / Not Supported	Noted with comments	

Comments:

PROJECT GOVERNANCE NEEDS TO BE LOOKED AT IN RELATION TO NEW RDU / SSP PROPOSED STRUCTURES, LESSONS LEARNT FROM THE PAST, IDENTIFICATION OF ISSUES AND PROGRAM REQUIREMENTS FOR AWARD OF DESIGN CONSULTANTS FOR B3&2 PROJECT (REFER ATTACHMENT WITH FURTHER COMMENTS).

ACT Government Health

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ACT Health Directorate Endorsement				
Redevelopment Unit Project Manager				
Supported / Not Supported		Noted with comments		Please discuss
.....	.....	...../...../.....		
Signature	Name	Date		
Comments / Conditions:				
Director Redevelopment Unit				
Supported / Not Supported		Noted with comments		Please discuss
.....	.....	...../...../.....		
Signature	Name	Date		
Comments / Conditions: As per PDR " " SCAP & SSP need to work through what we want & how we are going to deliver against "PC" scope & Budget. to PSP or FSP				
Executive Director Services and Capital Planning				
Approved / Not Approved		Noted with comments		Please discuss
.....	.....	...../...../.....		
Name	Signature	Date		
Comments / Conditions:				

PDR - 82

- No contract in place for PC before Caretaker period. realistic timing for earliest appointment will be.

December 2012.

=>. What to do in the interim time?

- ~~develop~~.

- what are issues:-

- scope creep. — Control user groups.
- Approval delays. — small teams reporting back to core and sticking to decisions.
- SSP / RDV Resourcing - — Direct + panel advisors.
- Maintaining overall project perspective. on total number of campus projects. — Role of PDC ✓ final say.
  Role of EXG ?
  Role of PCG ?
- procurement method for bldg 3/2 — options study.

PROJECT GOVERNANCE – CLIENT SIDE STRUCTURE | VERSION 1.0 | 11 July 2012

THINC HEALTH

Contents

THINC HEALTH

1.0 Overview

1.1 Context

Building 3, 2 Project on the HIP campus, is due to commence design in July/August 2012.The project will bring together Gross floor Area (GFA), of over 91,000 sqm, over 23 clinical services departments with construction cost exceeding [redacted] The average floor plate is in excess of 4000 sq.m at plinth level and can contain up to 5 different departments.

In order to work with the PC, for the design and the PSP / FSP level works; over 400+ meetings will be required in a period till December 2013.

At least 120 of these meetings will be required between now and end of PSP stage in April 2013. At least 20 of these key meetings/workshops with the PC's will be in the first 3 months of the PC's engagement, with further work required at the Health Directorate internal level to carry key users, HOD's along, through the design concept stage.

This is a critical stage and will require participation from strategic clinical leaders. It is anticipated that a monthly design cycle will be conducted by the PC and will require intensive involvement of the client side team.

1.2 Purpose

The purpose of this paper is to set out the Terms of Reference and Roles and Responsibilities of the various Groups, that may be required for the Building 3, 2 & Associated Works Package to manage and maintain the information flow to the designers through a formal governance and client instruction procedure.

It is the intent of this document that, the project will generally be administered in line with the ACTHD Governance Plan for the HIP projects (Project Governance and Committee Structure | Version 3.0 | 25 February 2009).

Specific detail has been added to existing governance structures through defined terms of reference for each group. This report documents the detailed description of these governance structures and their responsibilities and is submitted for comment and approval
No change or detailing of the ACT Health HIP Senior Committees or the Project Control Groups is proposed as part of the paper.

1.3 Existing Governance

The following is the summary of our understanding of the Roles of the existing project governance process:
The Redevelopment Committee is the Senior Project Committee for the HIP. It will provide a whole of government view on the conduct of, and progress on, the HIP. It will provide overall guidance on matters of policy, process and approvals.

The **Project Control Group** is the executive working group for the Redevelopment Committee. It will review information to be brought to the Redevelopment Committee and assess that information for applicability and robustness.

1.3.1 Governance Process

Through the planning and design processes, information will be created by the User Groups & stakeholder defined for each project as guided by the **Executive Reference Groups (ERG).**

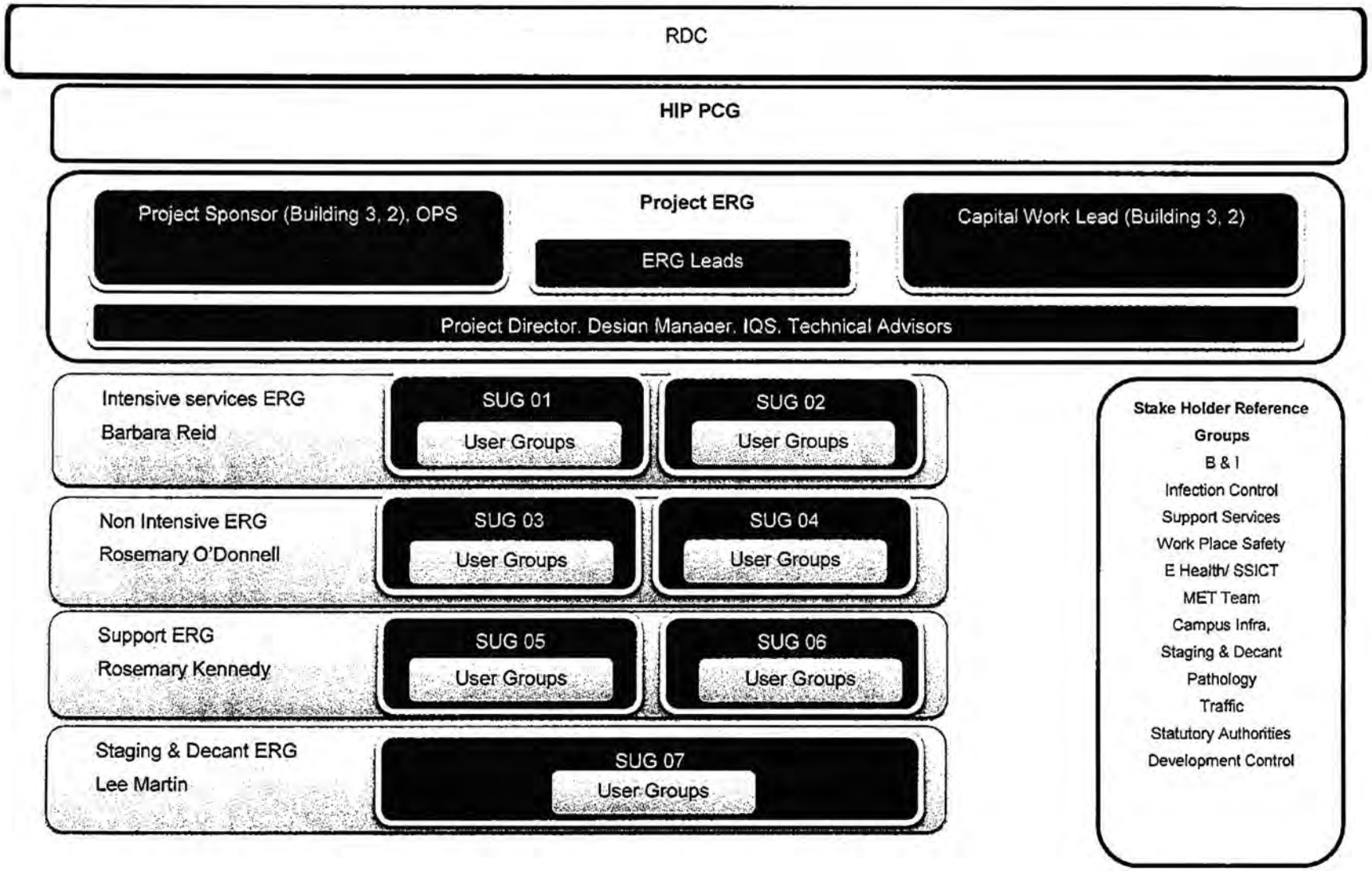
The ERG will refer matters of clinical policy to the appropriate Committee or Group for resolution. Once signed off by the User Groups, the project information will be forwarded to the relevant ERG for review and endorsement.
Once endorsed by the ERG, the project information will be forwarded to the relevant **Project Control Group (PCG)** also for review and endorsement.

Once endorsed, the information will be reviewed by the PCG and, if agreed, forwarded to the Redevelopment Committee for approval. The approval, or otherwise, will be communicated back through the committee structure at the appropriate time.

1.3.2 Reporting

Detailed project reports will be prepared on a monthly basis by the project specific Project Manager and Principal Consultants. These reports will be forwarded to the Project Director. The Project Director will review these reports and prepare a high level project report for submission to each PCG. An Executive Summary report will then be created by the Project Director for submission to the Redevelopment Committee towards the end each month.

Figure 1 HIP Program & Project Building 3, 2 Governance Interface



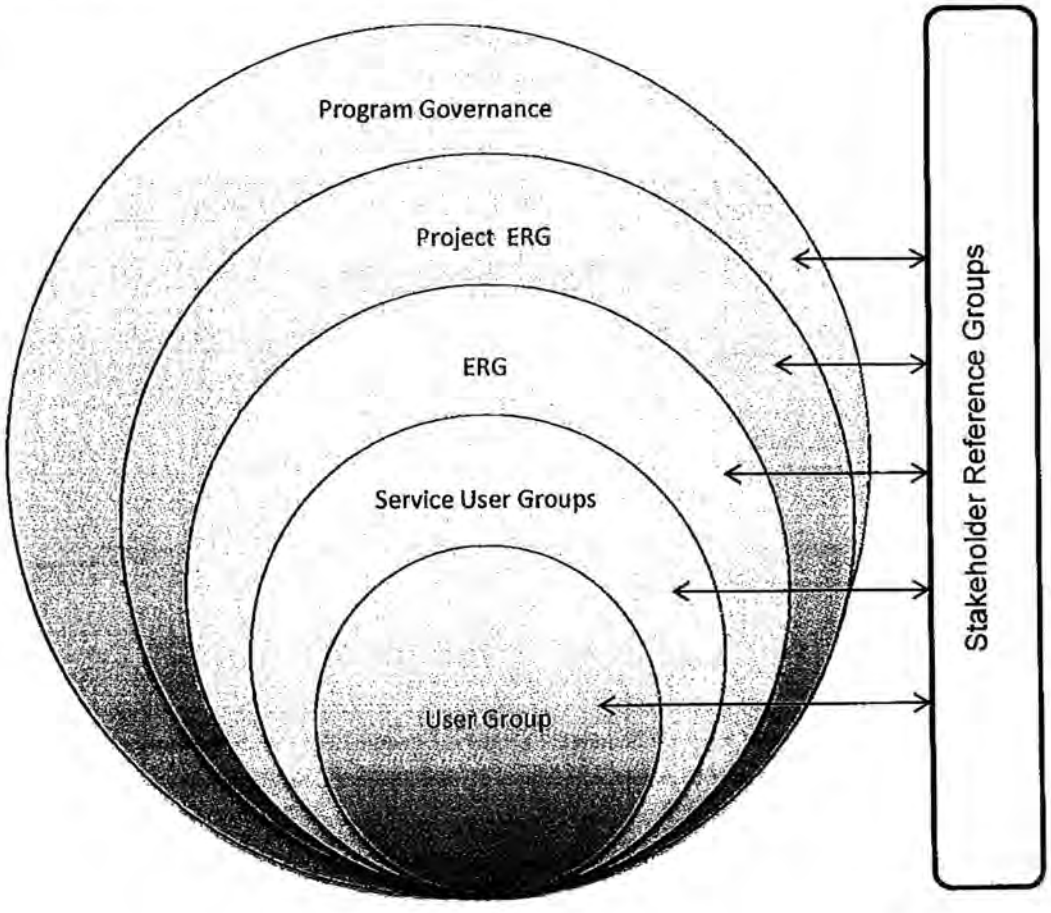
2.0 Proposed Project Governance Overview

Given the scale of the project, and a very high degree of inter-operability is required between the various departments, with synchronous workflows, it is recommended that the following hierarchy is put in place for the management of the workflows, while minimizing repetitive and insular groupings.

The overall program governance model is not affected by this proposal.

It is suggested that the project will generally be administered in line with the ACTHD Governance Plan for the HIP projects (Project Governance and Committee Structure | Version 3.0 | 25 February 2009). Specific detail has been added to existing governance structures through defined terms of reference for each group. This document provides the detailed description of these governance structures and their responsibilities.

Figure 2 B3, 2 Project Governance Structure



3.0 Project Consultation Groups

3.1 Executive Reference Groups

3.1.1 Primary Role

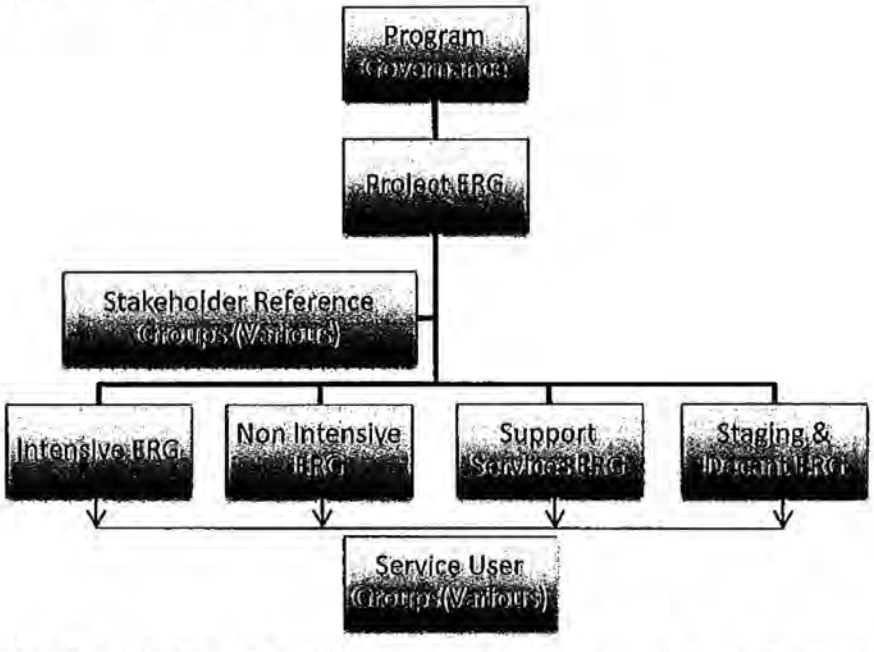
ERGs are responsible for facilitating the provision of expert advice on service delivery functional requirements on a project wide level. The ERG will be responsible for giving strategic direction to the project stakeholders, throughout the process of design, development and operational commissioning for this project.

The diverse requirements of the Services User Group/ Stakeholders, and the scale of the project means that, the project will have to be managed through up to 4 Clinical & Non Clinical ERGs; based on their common workflows and service user groups.

A separate Project ERG shall be put in place; to direct and control the Whole of Building design requirements; and guide & coordinate the 4 Clinical & Non Clinical ERGs.

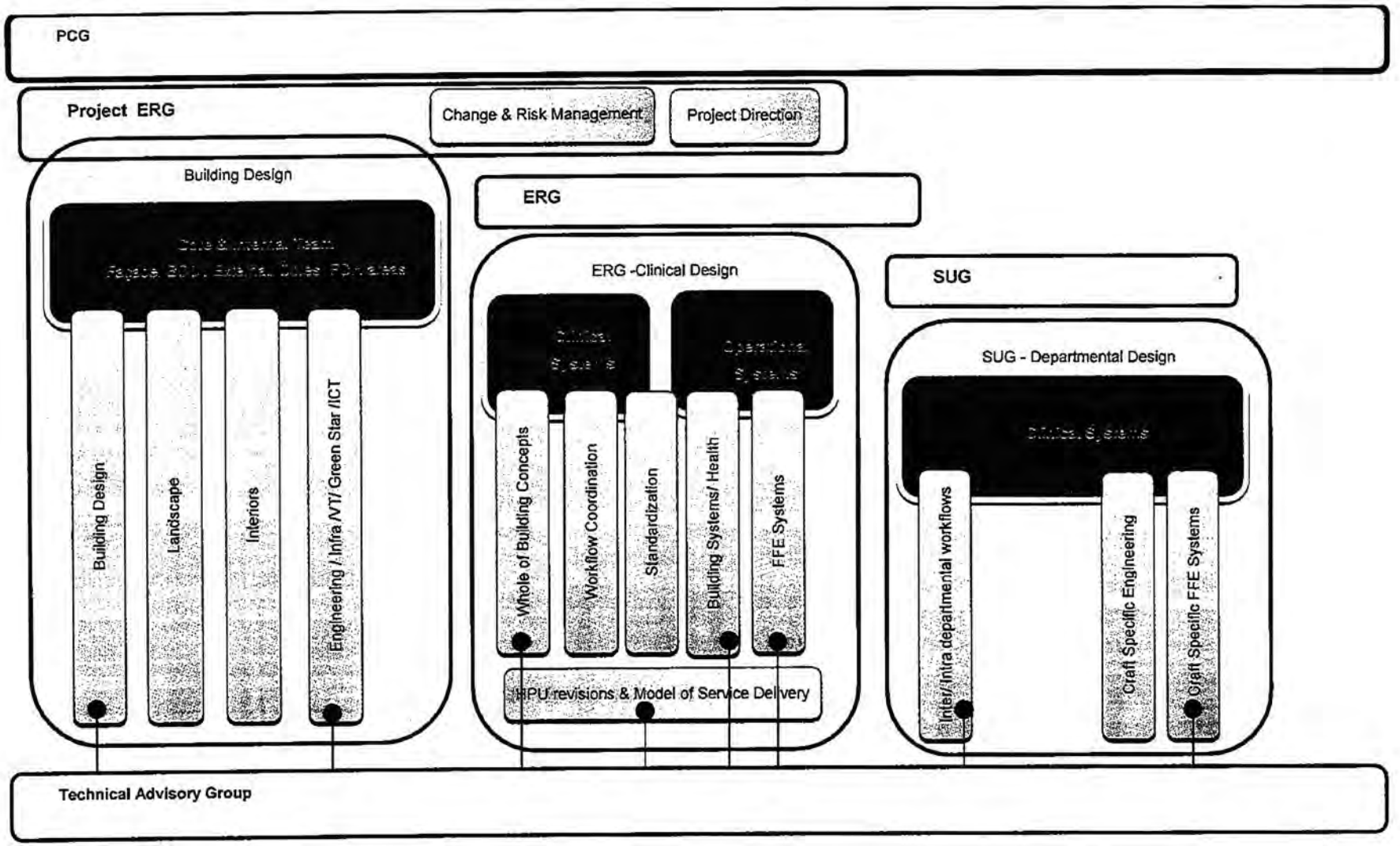
Each ERG will be the Lead consultation / user group for the relevant clinical or non-clinical stream of works. The Group will continue in this role until the redevelopment activities relating to the relevant HIP sub-project/s are complete.

Figure 3 ERG Structure



An ERG may establish further working groups to address particular issues as required.

Figure 4 Roles and Responsibilities



3.1.2 Terms of Reference and Responsibilities

The TOR for the ERG will also include responsibility as per the (Project Governance and Committee Structure | Version 3.0 | 25 February 2009). (Appendix A).

3.1.2.1 Project ERG

The Project ERG shall be specifically responsible for:

1. Project Building Design
    a. Building & Site Level design
    b. Engineering Design
    c. Whole of Building concepts (Interiors, Landscape, FM etc.)
    d. Critical review of design documents prepared during the project design phase as required;
    e. Coordinating information and requirements between the various ERG's; and Stakeholder Reference groups
2. Change Management*
    a. Scope Management
    b. Change Management
    c. Risk management;
3. Project Direction
    a. Project Cost
    b. Project Program
    c. Project implementation and delivery;
    d. Project management processes and procedures;
    e. Value management;
    f. Quality management;
    g. Communications Management.

**as per an approved change management protocol*

This group will be the primary lead for the Building and Infrastructure Design, with influence over the Clinical and Non Clinical ERG Led, Clinical Design Components where HIP level Agendas have to be coordinated, within the project.

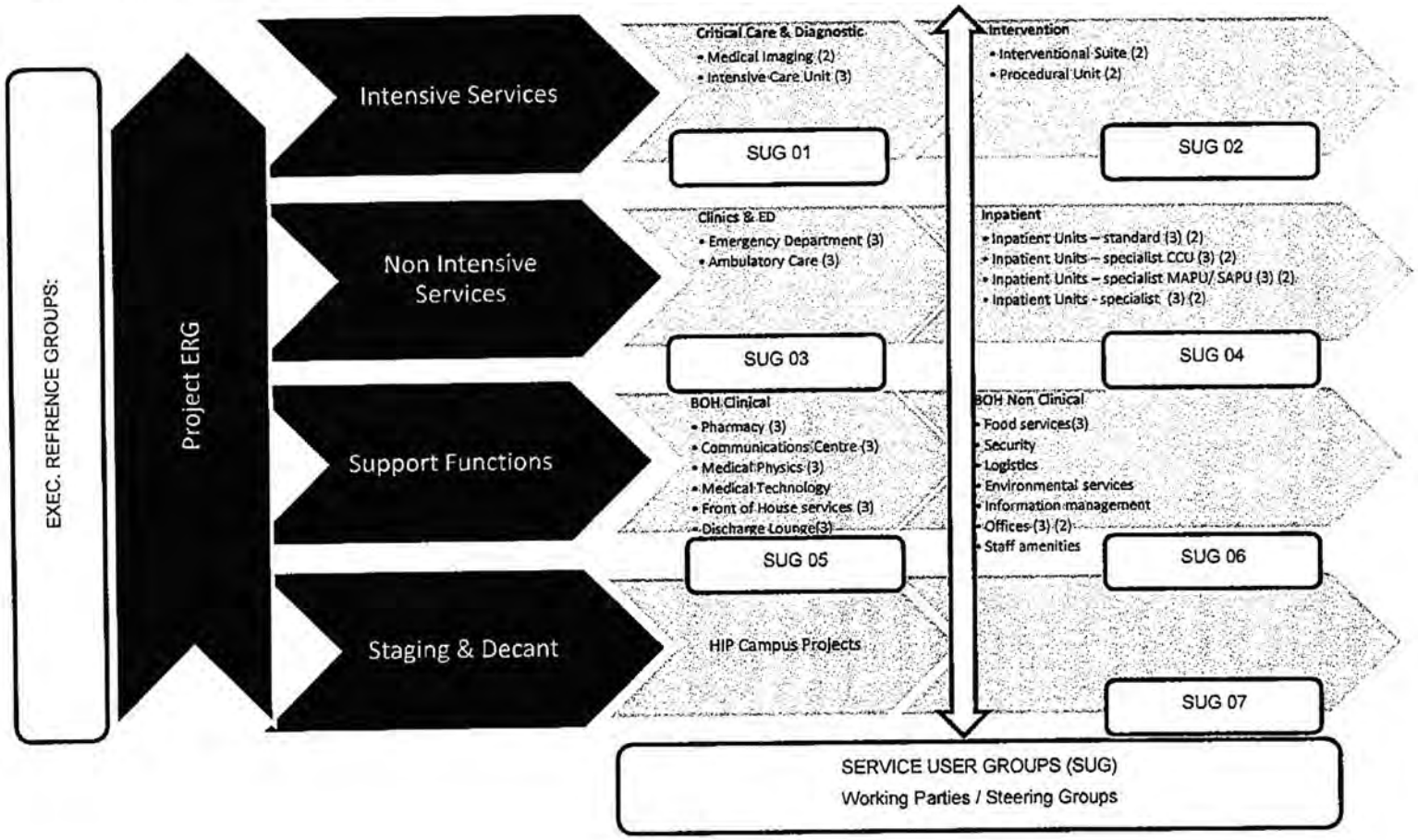
3.1.2.2 Clinical & Non Clinical ERGs

These groups will be responsible coordinating and managing the clinical design output on a 'Whole of Building Level' and shall be specifically responsible for:

1. Whole of building Clinical Delivery Concepts & operational planning
2. Workflow coordination in line with MOSD and HPU briefs
3. Health Engineering Requirements
4. Critical review of design documents prepared during the project design phase as required;
5. Standardization,
6. FFE requirements and planning
7. Cost
8. Continuity of service planning
9. Coordinating information and requirements between the various SUG

This group will also have influence on Building and Infrastructure Design, managed primarily through the Project ERG (pERG).

Figure 5 ERG Structure & Content



3.1.3 Membership

3.1.3.1 Project ERG

The Project ERG (pERG) shall be led by the Executive Director of Service and Capital Planning or delegate and will require representation from:

- Project Director
- Operational lead for the hospital,
- Capital Works lead for the project
- ERG Leads
- Project Design Manager
- IQS
- Tech Advisor Lead

3.1.3.2 Clinical & Non Clinical ERGs

The ERG's shall comprise of the key leads from the Service user Groups, as well as representation from the 4 pillars of the HIP process. The membership of the same shall be determined by the ERG leads.
The membership of each ERG will vary; however the of Chair of the ERGs will be determined by the PCG. ERG Meetings will be chaired by a representative of ACT Health.

3.1.4 Reporting Line

Each ERG will report through the pERG to the HIP PCG, which in turn reports to the ACT Health Redevelopment Committee through the PCG. ERGs will also provide and facilitate service user input to Project Director Meetings and Design Teams as appropriate.

All ERG outputs will be reviewed by the PCG prior to endorsement for consideration by the RDC.

Any unresolved issues that are critical to the completion of the Project design or implementation plan process will be referred to the pERG for resolution. Where this is not possible in the timeframe, the pERG will be asked to advice on the planning assumptions to be followed until the issue is resolved.
Any unresolved issues or issues requiring a greater delegation power will be escalated to the PCG.

3.1.5 Performance Indicators

The effectiveness of the Group will be evaluated on an ongoing basis by the Chairperson. The achievement of action plans will be monitored as a key indicator of performance and effectiveness.

3.1.6 Secretariat

The Principal Consultant will provide secretarial services to the ERGs during the design and delivery phases.

3.1.7 Conduct of Meeting

- **Frequency of Meetings:** It is envisaged that, at a minimum, monthly meetings will take place, with the key issues / outputs to be addressed at each meeting outlined

- **Location of Meetings:** Will be determined for each ERG.

- **Quorum:** Quorum is a majority of total members as determined by the appropriate Project Control Group (excluding invited members).
- **Decision Making**: Decisions will be made by general consensus of the meeting quorum. If a general consensus cannot be reached the Chairman will either: make a determination on the issue; raise an action item to be addressed by one or more of the ERG members; refer the issue to the relevant Service User Group or other relevant Group / Committee / Body for further consideration; or refer the issue to the relevant Project Control Group for guidance and / or determination. The ERGs will verify and endorse SUG recommendations for submission to the PCG.

- **Notice of Meetings:** A Notice of Meeting will be issued by the secretariat to group members one week before the subject meeting, at the latest. The Notice of Meeting will include:
    - Venue, date and time
    - Invitees
    - Agenda

The Action Statement of the previous meeting will be attached to the Notice of Meeting. Documents requiring a decision at the meeting will be distributed with the Notice of Meeting. Documents for information or consideration at the meeting will preferably be distributed with the Notice of Meeting, or will otherwise be distributed as early as possible prior to the meeting.

- **Standing Agenda Items:** There will be no standing agenda items as the agenda for each meeting will vary depending on the meeting purpose.

- **Minutes of Meetings:** A record of each meeting will be taken by the Secretariat in the form of Action Statements which will identify major comments and agreements and actions required by whom and by when.

3.1.8 Reporting

The ERGs will provide a Monthly Report to the PCG, which will address:

- Project Status;
- Major Issues and Recommendations;
- Planning Status and Update;
- Design Phase Status and Update;
- Construction Phase Status and Update;
- Communication and Consultation Issues;
- Co-ordination Issues;
- Budget and Cost Monitoring and Management;
- Programme;
- Risk Management; and
- OH&S Management.

3.2 Stakeholder Reference Group (SRG)

During the development of the project design & implementation several trade and operational level stakeholders will need to be consulted on a regular basis at specific milestones to ensure that critical project parameters have been met. **(Figure 1 HIP Program & Project Building 3, 2 Governance Interface)**

The stakeholders shall be formally consulted through focused reference groups and meetings for sign offs; for their trade specific specialisms.

The stakeholder groups identified shall be responsible for identifying any sub groups that may require consultation through the early phase on the project.

The reference groups shall also be responsible for contributing towards the 4 Pillars requirements of the wider HIP agenda. Key stakeholders reference groups identified to date*:

1. B & I
2. Hotel Services
3. Infection Control
4. Work Place Safety
5. E Health/ SSICT/ Technology
6. Bio Medical Engineering
7. MET Team
8. Campus Infra.
9. Staging & Decant
10. Pathology
11. Traffic
12. Statutory Authorities
13. Development Control
14. Procurement Services

**As the project develops further Stakeholder groups may become apparent and will require to be incorporated for consultation.*

3.2.1 Terms of Reference and Responsibilities

SRG will provide service specific advice to inform the planning during the concept design, schematic design and design development phases for their own specialist areas of operation and address specific issues referred by pERG or other ERGs

These groups will be responsible coordinating and managing the design output on a 'Whole of Building Level' and shall be specifically responsible for coordinating, and consulting on their trade specific specialist agendas and mandates; throughout the project design and implementation. Specific items that each of the stakeholder groups shall be individually responsible for shall be:

- Trade specific model of service delivery alignments
- Input into Planning & spatial requirements
- Trade Specific Engineering requirements
- Trade Specific FFE requirements

- Critical review of design documents prepared during the project design phase as required;
- Coordinating information and requirements between the stakeholders.

These groups will also have influence on overall building design requirements, managed by the pERG.

The SRG leads will be responsible for providing, regular input into the design stages , as requested by the pERG and ERGs

3.2.2 Membership

The membership of each SRG will vary and will determine in by the head of the specific SRG under direction by the appropriate ERG.

3.2.3 Reporting Line

Each SRG will report to the pERG and where direct interface is required to the clinical and non-clinical areas; specific ERG shall be reported to as well.

3.2.4 Performance Indicators

The effectiveness of the Group will be evaluated on an ongoing basis by the Chairperson of the pERG. The achievement of action plans will be monitored as a key indicator of performance and effectiveness.

3.2.5 Secretariat

The Principal Consultant will provide secretarial services to the SRGs during the design and delivery phases. Out of session meetings shall be document by the ACTHD project officer.

3.2.6 Conduct of Meeting

- **Frequency of Meetings:** will vary on a individual stakeholder group level. As a minimum consultation shall be undertaken during every single project stage or a maximum of 3 months.
- **Location of Meetings:** Will be determined for each SRG.
- **Quorum:** Quorum is a majority of total members as determined by the appropriate SRG (excluding invited members).
- **Decision Making:** Decisions will be made by general consensus of the meeting quorum. If a general consensus cannot be reached the Chairman will either: make a determination on the issue; raise an action item to be addressed by one or more of the SRG members; refer the issue to the relevant Service User Group or other relevant Group / Committee / Body for further consideration; or refer the issue to the relevant Project Control Group for guidance and / or determination. The pERGs will verify and endorse SRG recommendations for submission to the PCG.

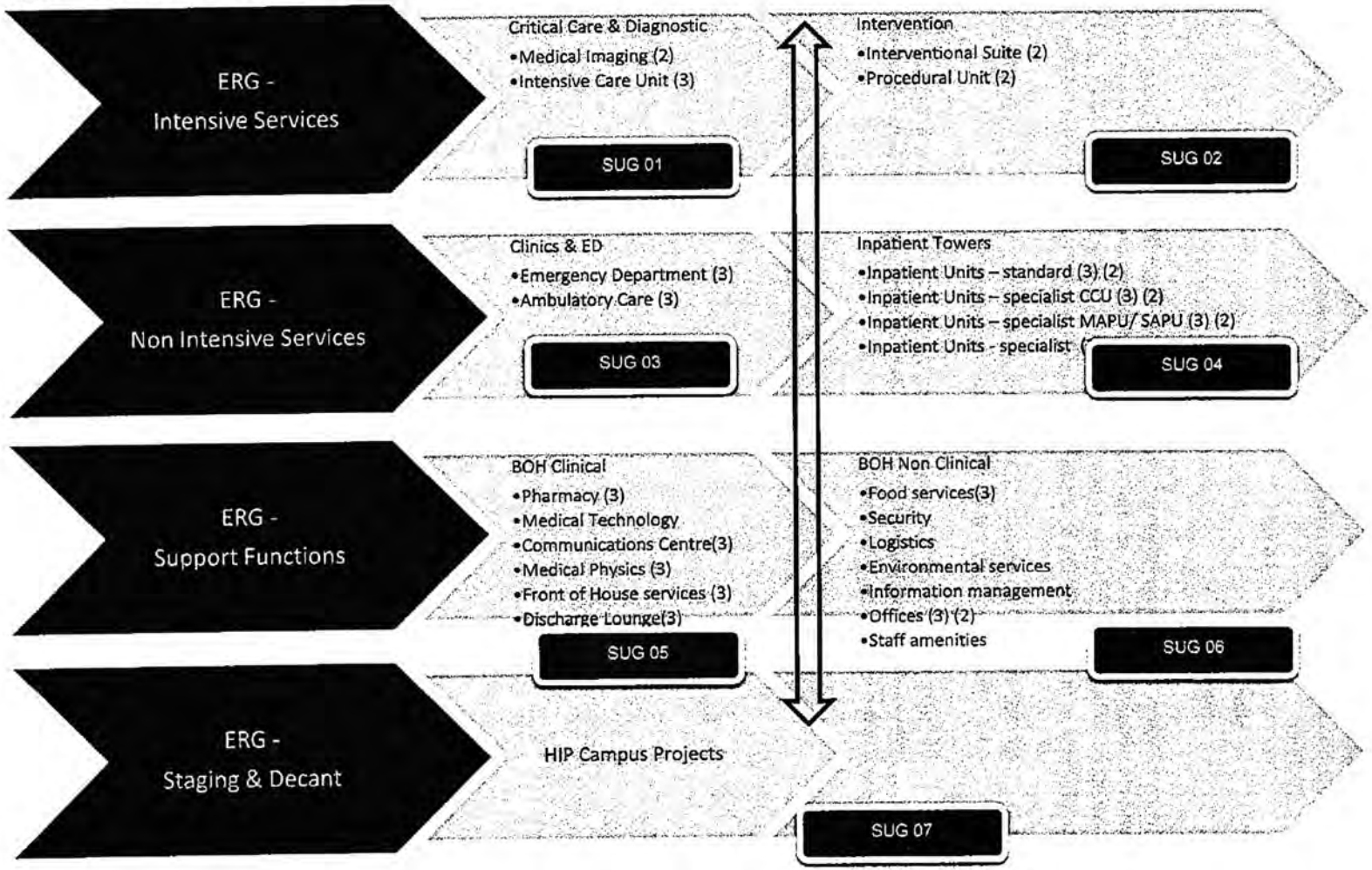
- **Notice of Meetings:** A Notice of Meeting will be issued by the secretariat to group members one week before the subject meeting, at the latest. The Notice of Meeting will include:
    - Venue, date and time
    - Invitees
    - Agenda

The Action Statement of the previous meeting will be attached to the Notice of Meeting. Documents requiring a decision at the meeting will be distributed with the Notice of Meeting. Documents for information or consideration at the meeting will preferably be distributed with the Notice of Meeting, or will otherwise be distributed as early as possible prior to the meeting.

- **Standing Agenda Items:** There will be no standing agenda items as the agenda for each meeting will vary depending on the meeting purpose.

- **Minutes of Meetings:** A record of each meeting will be taken by the Secretariat in the form of Action Statements which will identify major comments and agreements and actions required by whom and by when.

Figure 6 Clinical & Non Clinical SUG Structure



3.3 Service User Groups (SUG)

3.3.1 Primary Role

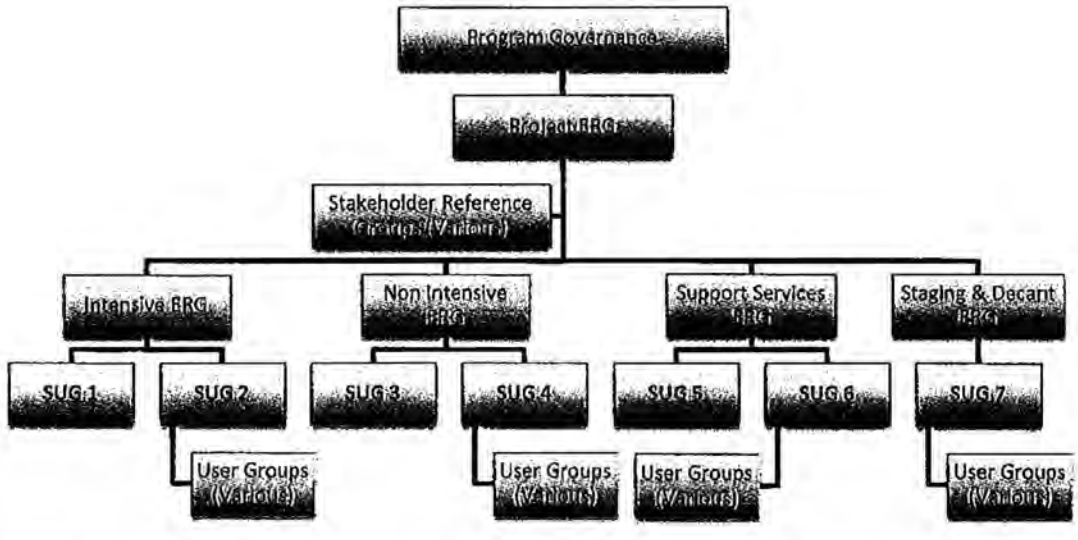
SUGs will the primary source for facilitating the provision of expert advice on service delivery & functional requirements on a

- Departmental
- Service stream and
- Hospital workflow level.
-

The SUG will be the lead consultation/user group for the specific Clinical & Non clinical ERG's .and each SUG member will have a responsibility to undertake consultation with relevant individuals within their working environment, through both formal and informal user groups ; using whatever mechanism is most suitable, to ensure that the full range of views is adequately considered by the design team.

The diverse requirements of the User Group/Stakeholders, and the scale of the project means that, the project will have to be managed through up to 7 SUG's ***(Figure 6);*** through their formally consolidated user groups and informal networks.. They will be reporting to a Specific ERG, who will take it through normal project governance channels. The following Structure is proposed for the SUG under the HIP project governance.

Figure 7 SUG Structure



Many Service User Groups (SUGs) will be established, as required, to facilitate Service User Consultation in relation to various ERGs ***(Figure 7)***

SUGs will be responsible for providing advice and recommendations regarding service user issues, models of care and functional requirements. SUG advice and recommendations must be consistent with the Service Delivery Models developed by the ERG.

3.3.2 Terms of Reference and Responsibilities

SUGs will provide service specific advice to inform the detailed planning during the schematic design and design development phases for specific Health Planning Units and address specific issues referred to the SUG by the ERG.

These groups will be responsible for coordinating, managing and delivering the end user requirements at departmental / service line level. For:

- Inter & intra-departmental workflow,
- Craft specific model of service delivery alignments
- Planning & spatial requirements
- Craft Specific Engineering requirements
- Craft Specific FFE requirements
- Critical review of design documents prepared during the project design phase as required;
- Coordinating information and requirements between the various User Groups & stakeholders.

These groups will also have influence on overall clinical design requirements, managed by the ERG. The SUG groups will be comprised of multiple clinical redesign groups/ working parties, etc. and will also include representation from the end users at the head end of service delivery.

The SUG leads will be responsible for the higher level floor layout planning under their responsibilities; whereas as the craft level end users shall be responsible for detail up to RDS and actual internal layout.

3.3.3 Membership

The membership of each SUG will vary and will determined in by the chair of the SUG under direction by the appropriate ERG. Each SUG meeting will be chaired by a representative of ACT Health.

Each SUG will contain a maximum of 10 people from a cross-section of disciplines and levels, and membership will be based on an individual's ability and skill to contribute. These criteria will be balanced with appropriate representation.

3.3.4 Reporting Line

Each SUG will report to the appropriate ERG. All documentation prepared by the SUG will be submitted to the ERG for endorsement prior to submission to the PCG for endorsement / approval and / or subsequently the Redevelopment Committee for approval if appropriate.

3.3.5 Performance Indicators

The effectiveness of each SUG will be evaluated on an ongoing basis by the Chairperson. The achievement of action plans will be monitored as a key indicator of performance and effectiveness.

3.3.6 Secretariat

The Principal Consultant will provide secretarial services to the SUGs during the design and delivery phases.

3.3.7 Conduct of Meetings

- **Frequency of Meetings:** Will be determined by the Principal Consultant for each HIP departmental or workflow group.

- **Location of Meetings:** Will be determined for each SUG. Meetings will be convened in a location convenient to clinical representatives.
- **Quorum:** Quorum is a majority of total members as determined by the appropriate SUG. (excluding invited members).
- **Decision Making:** Recommendations will be determined by general consensus of the meeting quorum. If a general consensus can not be reached the Chairman will either: raise an action item to be addressed by one or more of the SUG members; convene a working group to further investigate the issue; or refer the issue to the relevant ERG for guidance and / or determination. The SUG will develop recommendations for submission to the ERG for endorsement.
- **Notice of Meetings:** A Notice of Meeting will be issued by the secretariat to group members one week before the subject meeting, at the latest. The Notice of Meeting will include:
  - Venue, date and time
  - Invitees
  - Agenda

  The Action Statement of the previous meeting will be attached to the Notice of Meeting. Documents requiring a decision at the meeting will be distributed with the Notice of Meeting. Documents for information or consideration at the meeting will preferably be distributed with the Notice of Meeting, or will otherwise be distributed as early as possible prior to the meeting.
- **Standing Agenda Items:** There will be no standing agenda items as the agenda for each meeting will vary depending on the meeting purpose.
- **Minutes of Meetings:** A record of each meeting will be taken by the Secretariat in the form of Action Statements which will identify major comments and agreements and actions required by whom and by when.

3.4 User Groups

3.4.1 Primary Role

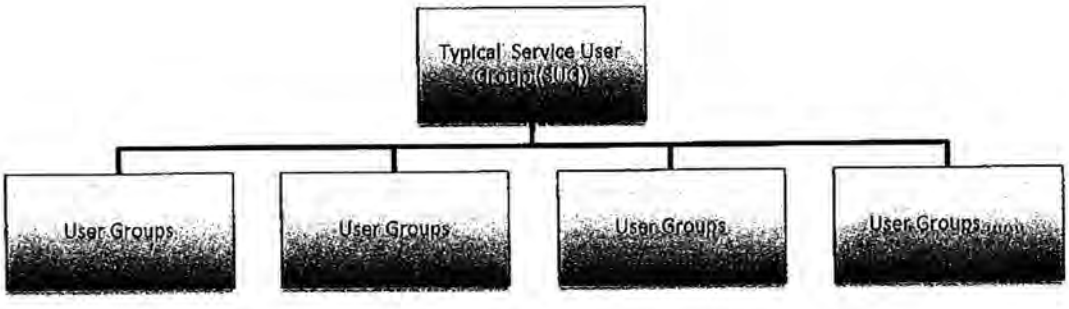
User Groups (UG) will be established to facilitate consultation regarding craft specific user requirements, in order to ensure that head end staff and stakeholders can have significant input into the design of this facility.

Due to the scale of the project and the intensity of the program, user groups will need to be consulted on a continual basis up to end of detailed design. In order to be most time efficient in this consultation process, individual groupings of the user groups will be established by the SUG; and timetabled, to allow for effective and efficient input.

The user groups will be required to commit time during specific design stages to receive information and to review and comment upon detailed deliverables of the Principal consultant for the design of their specific department or functional areas. The user groups will also be welcome to take the opportunity to comment on the overall strategies through their Service user groups, on overall building design, operational proposals.

The following Structure is proposed for the UG under the SUG and further HIP project governance.

Figure 8 User Groups Structure



3.4.2 Terms of Reference and Responsibilities

The UG will:

- Comment on design strategies and detailed deliverables
- Input in to improving patient care through design
- Clarify brief intent to designers on a craft and room level
- Comment on craft level technology, FFE and engineering requirements.

3.4.3 Membership

Membership of the UG will be determined on an ongoing basis by the SUG and if necessary by the ERG. The UG shall contain representation from a cross-section of disciplines and levels with membership based on an individual's ability and skill to contribute.

3.4.4 Reporting Line

The UG will report to the individual SUGs and will have specific opportunities through a formal design change process to the ERGs. .

Documentation prepared by the UG will require endorsement / approval by the SUG and ERG's and before following through the overall HIP project governance.

3.4.5 Performance Indicators

The effectiveness of the UG will be evaluated on an ongoing basis by the Chairperson of the SUGs and ERG. The achievement of action plans will be monitored as a key indicator of performance and effectiveness.

3.4.6 Secretariat

The ACTHD or delegate will provide secretarial services to the UG during the out of session consultation process. The Principal Consultant will provide secretarial services to the UG during the planned session on design and delivery phases.

3.4.7 Conduct of Meetings

- **Frequency of Meetings:** TBC
- **Location of Meetings:** TBC
- **Quorum:** Quorum is a majority of total members as determined by the SUG (excluding invited members).
- **Decision Making:** only direction & clarifications provided by the user groups. Directions provided by the users at this forum shall be endorsed by the SUG, where it is significantly different from the SUG strategy, before implementation. The project officer from ACTHD or PC shall record and seek confirmation of variant directions received at the user group level.
- **Notice of Meetings:** A Notice of Meeting will be issued by the secretariat to group members one week before the subject meeting, at the latest. The Notice of Meeting will include:
  - Venue, date and time
  - Invitees
  - Agenda

  The Action Statement of the previous meeting will be attached to the Notice of Meeting. Documents requiring a decision at the meeting will be distributed with the Notice of Meeting. Documents for information or consideration at the meeting will preferably be distributed with the Notice of Meeting, or will otherwise be distributed as early as possible prior to the meeting.

- **Standing Agenda Items:** There will be no standing agenda items as the agenda for each meeting will vary depending on the meeting purpose.
- **Minutes of Meetings:** A record of each meeting will be taken by the Secretariat in the form of Action Statements which will identify major comments and agreements and actions required by whom and by when.

ACT Government
Health

MINUTE

SUBJECT: **Advice on PDR 73: Building 3,2 Requirement for Technical Review Consultants**

To: Grant Carey-Ide, Executive Director Service & Capital Planning

From: Jacinta George, Senior Manager, Health Services Planning Unit

Date: 3 September 2012

Purpose

1. To provide advice about the content of Project Director Recommendation 73 Building 3,2 & Associated Works – Requirement for Technical Review Consultant(s)

Background

2. The PDR proposes 2 options for technical advice for the Building 3,2 project. The first is a Milestone Review model which has been budgeted for within the project estimates. The second option is an integrated review (or shadowing) model.

3. The version of the PDR tagged "Original" has been annotated by Shared Services – Procurement staff.

Issues

4. It is recommended that a working group comprising the Director RDU, Senior Manager HSPU, Construction Manager, Commissioning Lead and Director SS-P (HIP) provide a firm recommendation on the approach to technical advice for this project.

5. This advice should take into consideration:
    - the roles of the Design and Construction Managers, and whether the combination of these roles would perform the Lead Technical Advisor role proposed in the PDR.
    - The process for engaging ad hoc (in addition to Milestone) review and advice.
    - The complementary role of the Expert Advisory Panel that will be established for HIP.
    - Reporting channels. I assume that while the Expert Advisory Panel would report to the Executive Director, Service & Capital Planning and/or the Director-General on specific projects, the Technical Review Consultants would report to the Director Redevelopment Unit.

Recommendations

That you note the information above when considering PDR 73.

AGREED/NOT AGREED/NOTED/PLEASE DISCUSS

.....

Grant Carey-Ide
Executive Director
Service & Capital Planning
...../...../.....

ACT Government
Health

MINUTE

SUBJECT: **Advice on PDR 82: Building 3,2 Project Governance: Brief Verification and Design Phases**

To: Grant Carey-Ide, Executive director Service & Capital Planning

From: Jacinta George, Senior Manager, Health Services Planning Unit

Date: 3 September 2012

Purpose

1. To provide advice about the content of Project Director Recommendation 82: Building 3,2 & Associated Works – Client Side Project Governance and Resourcing.

Background

2. This PDR focuses on the User Group through to Executive Reference Group governance for this project.

3. The recommendation has been formed following discussions with myself about Health Directorate processes.

4. The focus of the PDR is on resourcing of the significant number of meetings that will be required in order to finalise the Brief Validation and Design pahses of the project. The Resource table at the back of the papers shows the basis for the calculations on the significant resources that will be required to support this project.

5. Salient points in the PDR have been highlighted and annotated on the attached.

Issues

6. The PDR recommends a structure of
    - User Groups
    - Service User Groups
    - Executive Reference Groups
    - Project Reference Group
    - Reporting through to HIP PCG and RDC.

7. The Project ERG would perform an important decision making role, making decisions (about the project within a program framework) that fall within the members' position responsibility (the ED, Service and Capital Planning, Deputy Director-General CHHS, ERG chairs, Director RDU and Senior Manager HSPU and Construction and Design Managers) to allow the Principal Consultant, ERGs and User Groups to receive feedback quickly on project issues.

8. The PDR notes that the Principal Consultant will be secretariat to the ERGs, however the Facility Planning/Commissioning Officers from Service & Capital Planning Branch would assume responsibility for briefing the Project ERG about significant issues for decision.

9. The Project ERG would largely be able to make decisions, and recommendations to PCG and RDC, based on the membership positional delegations but may from time to time call on the Expert Advisory Panel through the Executive Director, Service & Capital Planning, or technical advisers from the project panel to assist in decision making.

10. The role of the ERG would be to provide expert advice on service delivery functional requirements project wide. User Groups/Service User Groups would be fora for coalface input & consultation about craft specific user requirements.

11. The paper envisages a rolling program of meetings monthly: the project ERG would meet at the conclusion of each cycle so that outstanding issues can be dealt with and the Principal Consultant move into the next phase of consultation meetings.

12. An alternate option to the model proposed would be for the Health Services Planning Unit facility planners to meet with the Principal Consultants in the early stages of Brief Validation to provide interpretation relating to the HPU Briefs. A weekly meeting with the ERG chairs would keep them informed about information that is being shared with the Principal Consultant, and minimise CHHS resources that need to be invested at that early stage of the project.

13. The options for the Brief Validation period will be discussed at a meeting with CHHS Executive, as requested by Mr Martin some weeks ago. Feedback will be provided to you following that meeting.

14. There will be a Project Director Meeting for this project, as for all other HIP projects, which will drive the delivery of the project within scope and budget. The PDM will consist of representation from Shared Services Procurement, Director Redevelopment Unit, Senior Manager Health Services Planning Unit, Design Manager, Construction Manager and other key Redevelopment Unit staff.

Recommendations

That you note the information above when considering PDR 82

AGREED/NOT AGREED/NOTED/PLEASE DISCUSS

.....

[redacted]

Grant Carey-Ide
Executive Director
Service & Capital Planning
15/10/12

ACT Government
Health

HIP Project Request

HIP PR 103

SUBJECT: Commercial Advisor Engagement to Support Building 3/2 Delivery Model Analysis

To: Grant Carey-Ide, Executive Director, Service and Capital Planning

Endorsed: Adrian Scott, Director, Redevelopment Unit [redacted] 4/10/12

From: Ken Russell, Senior Project Officer Shared Services Procurement

Date: 3rd October 2012

Purpose

To seek your agreement to issue a Brief to engage a Commercial Advisor to assist Health Directorate's Redevelopment Unit (RDU) and Shared Services Procurement (SSP) to decide on the optimum delivery model for the The Canberra Hospital (TCH) Building 3/2 and Associated Works Redevelopment project.

Background

2. Following DG approval in August 2012 preferred Principal Consultant (PC) tenderer is currently in negotiation with Health Directorate following a successful tender evaluation process undertaken earlier in 2012. Expected contract award for PC is December 2012 based on schedule contained in Attachment A.
3. A key element of the PC contract negotiations is to confirm the optimal design stage to approve without over expending available funding on more detailed design that may well never eventuate as a finished building, due to various reasons e.g. scope, project risks and constructability issues. Design phasing options available are :
    a. Planning Concept & Validation (P&CV)
    b. Preliminary Sketch Plan (PSP)
    c. Final Sketch Plan (FSP)
4. It is anticipated that following PC contract award the PC will take design to PSP stage as this will provide all project stakeholders with a more meaningful costed reference design that will be used to revalidate the project business case prior to committing additional funding to project. (Contract currently being negotiated with PC is a milestone based program that could be taken to FSP stage based on current available funding.)
5. Early planning for Building 3/2 development was based on a plan to develop a building design to PSP and/or FSP stage, following which control of the PC maybe novated across to a Managing Contractor (MC) to complete and deliver a project to agreed timeframe, scope and budget.

Issue

6. [redacted]
7. Based on recently introduced Treasury Capital Infrastructure Development guidelines Building 3/2 development is ranked as a Tier 3 (Highest) project for its' high capital cost and project complexity.
8. The Building 3/2 development project at TCH is the biggest capital infrastructure project to be undertaken by the HD. The project will be a challenge on many fronts from scope variation and latent conditions to internal and external stakeholder management. Due to the project scale and community impact it is a necessary risk mitigation to engage professional advice to support the RDU/SSP team in choosing the optimal procurement delivery model for this project.
9. The proposed Brief to engage a suitably qualified Commercial Advisor is a per Attachment B
10. Anticipated timing to produce a Delivery Model Analysis report for this project is expected to be 5 months as per summary below:
    a. Request for Proposal (RFP) from recently convened Commercial Advisory Panel within SSP. *2 Weeks*
    b. Proposal preparation. *3 weeks*
    c. Proposal evaluation and Oral Presentation. *3 Weeks*
    d. Assignment Execution:
        i. Preliminary Delivery Model Assessment. *3 weeks*
        ii. Market Sounding. *3 weeks*
        iii. Conclusion of analysis. *2 weeks*
    e. Report generation and presentation. *3 weeks*.
11. Assuming commencement of above process in mid October 2012 it is anticipated to have a completed Delivery Model Analysis report available in March 2013

Funding

12. Based on 2011/12 budget $41M is available for the design of Enhanced Facilities at TCH. Funding for the Commercial Advisor project is available from this appropriation.
13. Commercial advisory costs to facilitate a Market sounding process and subsequent Delivery Model Analysis is estimated to be in the order of $250K

Approval

14. Engagement of a Commercial Advisor to assist the RDU/SSP project team in the selection of the optimal delivery model option that can be used on the Building 3/2 project to maximize project value for money based on available funding and optimum risk transfer for the ACT Government

15. Engagement of a Commercial Advisor during Caretaker period noting that the advice to be provided is not considered politically contentious as the Report outcome will be of benefit to the Government irrespective of political persuasion.

Recommendations

That you:

- Note the information contained in this HIP Project Request;

AGREED/NOT AGREED/NOTED/PLEASE DISCUSS

- Approve the engagement of a Commercial Advisor for the Building 3/2 Redevelopment project to conduct Market Sounding and a Delivery Model Analysis to support future Territory decision making on this project.

AGREED/NOT AGREED/NOTED/PLEASE DISCUSS

- Approve the awarding of a Contract during Caretaker period in accordance with agreed conventions.

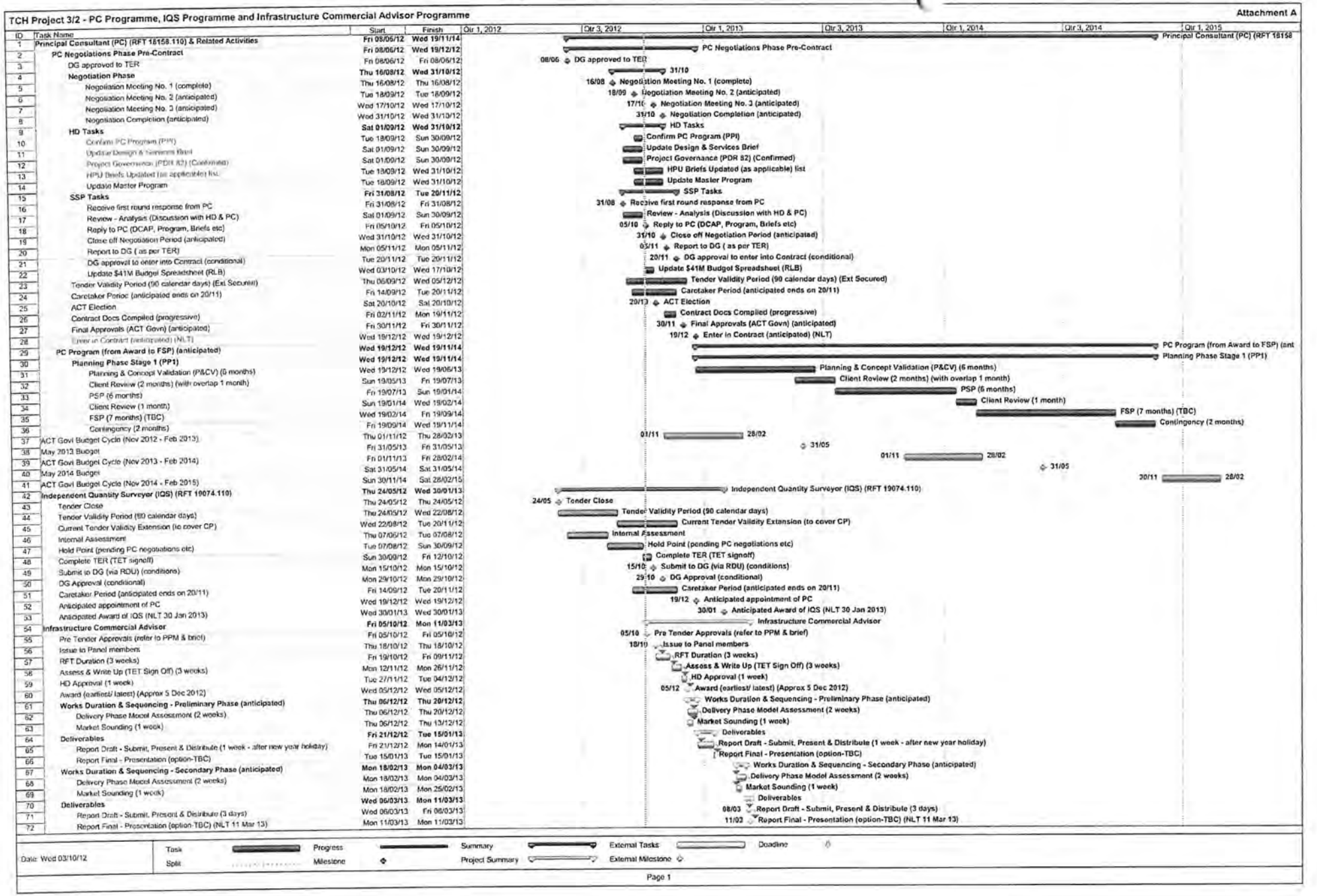
AGREED/NOT AGREED/NOTED/PLEASE DISCUSS

Grant Carey-Ide
Executive Director
Service and Capital Planning
2012

[redacted]
Colm Mooney
A/g Director
Shared Services Procurement HIP
4th Oct. 2012

Ken Russell
Extension: 70098

Attachment A



ID	Task Name	Start	Finish
1	**Principal Consultant (PC) (RFT 18158.110) & Related Activities**	**Fri 08/06/12**	**Wed 19/11/14**
2	**PC Negotiations Phase Pre-Contract**	Fri 08/06/12	**Wed 19/12/12**
3	DG approved to TER	Fri 08/06/12	Fri 08/06/12
4	**Negotiation Phase**	**Thu 16/08/12**	**Wed 31/10/12**
5	Negotiation Meeting No. 1 (complete)	Thu 16/08/12	Thu 16/08/12
6	Negotiation Meeting No. 2 (anticipated)	Tue 18/09/12	Tue 18/09/12
7	Negotiation Meeting No. 3 (anticipated)	Wed 17/10/12	Wed 17/10/12
8	Negotiation Completion (anticipated)	Wed 31/10/12	Wed 31/10/12
9	**HD Tasks**	**Sat 01/09/12**	**Wed 31/10/12**
10	Confirm PC Program (PPI)	Tue 18/09/12	Sun 30/09/12
11	Update Design & Services Brief	Sat 01/09/12	Sun 30/09/12
12	Project Governance (PDR 82) (Confirmed)	Sat 01/09/12	Sun 30/09/12
13	HPU Briefs Updated (as applicable) list	Tue 18/09/12	Wed 31/10/12
14	Update Master Program	Tue 18/09/12	Wed 31/10/12
15	**SSP Tasks**	**Fri 31/08/12**	**Tue 20/11/12**
16	Receive first round response from PC	Fri 31/08/12	Fri 31/08/12
17	Review - Analysis (Discussion with HD & PC)	Sat 01/09/12	Sun 30/09/12
18	Reply to PC (DCAP, Program, Briefs etc)	Fri 05/10/12	Fri 05/10/12
19	Close off Negotiation Period (anticipated)	Wed 31/10/12	Wed 31/10/12
20	Report to DG (as per TER)	Mon 05/11/12	Mon 05/11/12
21	DG approval to enter into Contract (conditional)	Tue 20/11/12	Tue 20/11/12
22	Update $41M Budget Spreadsheet (RLB)	Wed 03/10/12	Wed 17/10/12
23	Tender Validity Period (90 calendar days) (Ext Secured)	Thu 06/09/12	Wed 05/12/12
24	Caretaker Period (anticipated ends on 20/11)	Fri 14/09/12	Tue 20/11/12
25	ACT Election	Sat 20/10/12	Sat 20/10/12
26	Contract Docs Compiled (progressive)	Fri 02/11/12	Mon 19/11/12
27	Final Approvals (ACT Govn) (anticipated)	Fri 30/11/12	Fri 30/11/12
28	Enter in Contract (anticipated) (NLT)	Wed 19/12/12	Wed 19/12/12
29	**PC Program (from Award to FSP) (anticipated)**	**Wed 19/12/12**	**Wed 19/11/14**
30	**Planning Phase Stage 1 (PP1)**	**Wed 19/12/12**	**Wed 19/11/14**
31	Planning & Concept Validation (P&CV) (6 months)	Wed 19/12/12	Wed 19/06/13
32	Client Review (2 months) (with overlap 1 month)	Sun 19/05/13	Fri 19/07/13
33	PSP (6 months)	Fri 19/07/13	Sun 19/01/14
34	Client Review (1 month)	Sun 19/01/14	Wed 19/02/14
35	FSP (7 months) (TBC)	Wed 19/02/14	Fri 19/09/14
36	Contingency (2 months)	Fri 19/09/14	Wed 19/11/14
37	ACT Govt Budget Cycle (Nov 2012 - Feb 2013)	Thu 01/11/12	Thu 28/02/13
38	May 2013 Budget	Fri 31/05/13	Fri 31/05/13
39	ACT Govt Budget Cycle (Nov 2013 - Feb 2014)	Fri 01/11/13	Fri 28/02/14
40	May 2014 Budget	Sat 31/05/14	Sat 31/05/14
41	ACT Govt Budget Cycle (Nov 2014 - Feb 2015)	Sun 30/11/14	Sat 28/02/15
42	**Independent Quantity Surveyor (IQS) (RFT 19074.110)**	**Thu 24/05/12**	**Wed 30/01/13**
43	Tender Close	Thu 24/05/12	Thu 24/05/12
44	Tender Validity Period (90 calendar days)	Thu 24/05/12	Wed 22/08/12
45	Current Tender Validity Extension (to cover CP)	Wed 22/08/12	Tue 20/11/12
46	Internal Assessment	Thu 07/06/12	Tue 07/08/12
47	Hold Point (pending PC negotiations etc)	Tue 07/08/12	Sun 30/09/12
48	Complete TER (TET signoff)	Sun 30/09/12	Fri 12/10/12
49	Submit to DG (via RDU) (conditions)	Mon 15/10/12	Mon 15/10/12
50	DG Approval (conditional)	Mon 29/10/12	Mon 29/10/12
51	Caretaker Period (anticipated ends on 20/11)	Fri 14/09/12	Tue 20/11/12
52	Anticipated appointment of PC	Wed 19/12/12	Wed 19/12/12
53	Anticipated Award of IQS (NLT 30 Jan 2013)	Wed 30/01/13	Wed 30/01/13
54	**Infrastructure Commercial Advisor**	**Fri 05/10/12**	**Mon 11/03/13**
55	Pre Tender Approvals (refer to PPM & brief)	Fri 05/10/12	Fri 05/10/12
56	Issue to Panel members	Thu 18/10/12	Thu 18/10/12
57	RFT Duration (3 weeks)	Fri 19/10/12	Fri 09/11/12
58	Assess & Write Up (TET Sign Off) (3 weeks)	Mon 12/11/12	Mon 26/11/12
59	HD Approval (1 week)	Tue 27/11/12	Tue 04/12/12
60	Award (earliest/ latest) (Approx 5 Dec 2012)	Wed 05/12/12	Wed 05/12/12
61	**Works Duration & Sequencing - Preliminary Phase (anticipated)**	**Thu 06/12/12**	**Thu 20/12/12**
62	Delivery Phase Model Assessment (2 weeks)	Thu 06/12/12	Thu 20/12/12
63	Market Sounding (1 week)	Thu 06/12/12	Thu 13/12/12
64	Deliverables	**Fri 21/12/12**	**Tue 15/01/13**
65	Report Draft - Submit, Present & Distribute (1 week - after new year holiday)	Fri 21/12/12	Mon 14/01/13
66	Report Final - Presentation (option-TBC)	Tue 15/01/13	Tue 15/01/13
67	**Works Duration & Sequencing - Secondary Phase (anticipated)**	**Mon 18/02/13**	**Mon 04/03/13**
68	Delivery Phase Model Assessment (2 weeks)	Mon 18/02/13	Mon 04/03/13
69	Market Sounding (1 week)	Mon 18/02/13	Mon 25/02/13
70	Deliverables	**Wed 06/03/13**	**Mon 11/03/13**
71	Report Draft - Submit, Present & Distribute (3 days)	Wed 06/03/13	Fri 08/03/13
72	Report Final - Presentation (option-TBC) (NLT 11 Mar 13)	Mon 11/03/13	Mon 11/03/13

Attachment B

Advisory Brief

Client: Health Directorate

Title: Commercial Advice in relation to Building 3/2 Redevelopment at The Canberra Hospital (TCH).

Date of Issue: 3rd October 2012

Background

- The Government has appropriated funding as part of the redesign activities associated with Building 3/2 at TCH
- A proposed method of construction will be recommended during the Preliminary Sketch Plan (PSP) design stage of works.
- A submission seeking further funding for full design and subsequent construction may be considered by Government for the 2014-15 financial year.

Nature of Advice

The Health Directorate (HD) is seeking an advisor with extensive experience in providing comprehensive advice on major infrastructure projects including:

- Developing and facilitating market soundings for major projects
- Evaluation and assessment of procurement and delivery models for infrastructure projects
- Experience in full procurement commercial support through to contractual close (note that this service is not included in this stage of the brief, however the expertise should be demonstrated)

Scope of Work

The role of the advisor will be to provide advice to Health in conjunction with ACT Treasury (Shared Services Procurement) in the following areas:

1. Preliminary Delivery Model assessment
2. Market Sounding Process
    a. Work with the client to develop a list of questions to test preliminary issues in relation to delivery model and commercial principles
    b. Facilitate a market sounding process in the ACT and a second location (likely to be Sydney) to seek comment from potential contractors on the identified issues
    c. Prepare a brief report (10-20 pages) summarising the responses, outcomes, and preliminary recommendations from the market sounding process

3. Delivery Model Assessment
    a. Facilitate necessary workshops with relevant government stakeholders to assess the commercial risk profile of the Project
    b. Assess the Project's characteristics and risk profile against a range of criteria to identify the commercial principles that will inform the delivery model
    c. Identify suitable delivery models which represent effective risk transfer for the Territory given the Project's characteristics
    d. Recommended delivery model

4. Report
    a. The advisor will be required to prepare both
        i. A report summarising the assessment of the project and an evaluation against potential delivery models; and,
        ii. Deliver a summary presentation (MS PowerPoint) of their findings.

A preliminary draft report and presentation will be required to be submitted for Client review and comment prior to draft report finalisation and presentation to the relevant government stakeholders.

After the draft report is finalised, it will be circulated to government stakeholders for agency comments. The consultant should provide for attendance at two meetings to speak to the presentation and to liaise with agencies on their comments.
The consultant's report should include the following structure:

- Executive Summary – summary of report content and key findings
- Cost Estimates
- Economic Analysis (The economic analysis will be updated to incorporate any changes necessary after the risk analysis)
- Risk Analysis – an assessment of the risk profile of project
- Commercial Principles – based on the risk analysis; a brief summary of commercial principles that inform delivery model assessment
- Delivery Model – an identification of the potential delivery models and an assessment of compatibility against the Project's characteristics
- Recommendation – the recommended delivery model(s) and rationale
- Optional (at advisor's cost) – suggestions, scoping, and/or costing for further assistance and commercial advice during procurement, (to be considered at the Territory's unfettered discretion)

Duration

It is expected that the market sounding and draft report will be completed in no more than eleven weeks from commencement of the engagement.

Cost

Respondents to this brief should provide a binding fixed fee offer including:

- A breakdown of work by team member and rates and hours
- A summary of relevant incidentals and disbursements.

Timing

Responses to this brief are due at 2.00pm on Thursday 1st November 2012.

Presentation of Proposal and Team

Respondents may at their own discretion offer to provide a presentation of their proposal to the Evaluation Team. This presentation would be envisaged to be up to one hour, MS PowerPoint based, and include an active representation of the proposed team across levels e.g. (Partner, Associate Director, Senior Consultant or equivalents).

The team member who will undertake the majority of the work is expected to be nominated, provide part of the presentation and field questions. The bulk of the activity should be led by a single nominated partner with appropriate experience in a wide range of delivery model options with support and specialist input able to be deployed as necessary.

The presentation of the proposal will be at the Respondent's own cost, and conducted in the ACT.
Respondents should indicate in their covering letter whether they are prepared to undertake this presentation.

Contact

Enquiries regarding this brief should be directed to Ken Russell:

E: ken.russell@act.gov.au

P: 02 6207 0098

ACT Government
Health

MINUTE

SUBJECT: **Building 3 & 2 Project Management Framework**

To: Grant Carey-Ide, Executive Director

From: Jacinta George, Senior Manager Health Services Planning Unit

Date: 19 October 2012

Purpose

1. To propose a framework for the management of the Building 3 & 2 project within Service & Capital Planning Branch.

Background/Issues

2. The complexity of the Building 3 & 2 project was discussed at the Executive Planning Day on 10 September and you requested a proposal about the framework within which the project should be managed within the Branch.

3. The project will commence the Design (Project Validation) phase on appointment of the Principal Consultant (PC) and move into Preliminary Sketch Plan and Final Sketch Plan stages thereafter, subject to approvals.

4. Construction funding has not yet been appropriated.

5. Health Services Planning Unit (HSPU) has been working with stakeholders to update the Health Planning Unit (HPU) Briefs relevant to new Buildings 3 & 2 incorporated in the Project Definition Plan (PDP) for HIP.

6. Redevelopment Unit (RDU) has been managing a number of projects that also form the basis of the PDP for this project, such as the Master Documentation Library, Campus Infrastructure and Staging and Decanting projects.

7. The previous Project Director, Thinc developed the Services Brief and Design Brief for the procurement of the PC, incorporating feedback from Shared Services Procurement (SS-P) and Redevelopment Unit (RDU).

8. A Project Director Meeting for this project was coordinated by Thinc as Project Director. The meeting included representation from Shared Services-Procurement, Director Redevelopment Unit, Senior Manager Health Services Planning Unit, Design Manager, Construction Manager and other key Redevelopment Unit staff. The Senior Manager HSPU has assumed the Chair and organisation of the meetings, until such time as it is coordinated by RDU, to ensure continuity until the governance arrangements for this project are finalised.

9. Shared Services Procurement has lead the procurement and contract negotiation processes for the appointment of the Principal Consultant.

10. A technical advisory role to HSPU/RDUas Design Manager, responsible for has been established and Thinc Health has been appointed (Saurabh Bhandari) to undertake that role until December 2012, pending agreement on the management framework for the project.

11. This role is responsible for providing proactive strategic advice to the Senior Manager HSPU and Director RDU on effective processes for client input and review during the design process, to ensure that relevant client documentation is available and considered by the PC, and that the design outcome aligns with project scope.

12. SSP has proposed to you the appointment of a Design Project Officer from a Panel Contract for Project Directors/Superintendents (Hospital/Health) Services. This position would manage the project through the Design phase including management of budget and program and be responsible for the management and resolution of design issues. This role differs from that contracted to Thinc (#10 above) in that it is a management rather than technical advisory role.

13. You have requested (PDR 73 response) that the details of the Technical Advisory function for the project be agreed and recommended to you. This will include a recommendation on the appointment of an External Expert Advisory Panel.

14. The HIP Program & Construction Director and SS-P have recommended that an additional review of the documentation available to inform the design of Buildings 3 & 2 be undertaken in addition to the advice being provided by Saurabh Bhandari. I have accepted the advice of the Construction Manager that a further external review (in addition to the previous role of Thinc as Project Director and as Design Manager, and the role that the PC will play during the validation period) will provide a value-for-money further level of

assurance about preparedness for the design phase. This review can be procured from the Health Services Planning Panel Contract.

15. Consideration is being given to the role of Design Manager across HIP.

16. The facility planning role of Health Services Planning Unit and the management of the design and construction phases through Redevelopment Unit will merge at the point of appointment of the Principal Consultant.

17. The Design phase of HIP projects has historically been a responsibility of RDU. It is recognised that HSPU has an ongoing role in ensuring that the design phase remains consistent with the HPU Briefs and underpinning assumptions. You have indicated that you are reviewing this structure.

18. A number of process improvements have been implemented recently to ensure continuity and consistency of planning through to design and construction. These include the planned co-location of the HSPU and RDU/SS-P teams, and the appointment of facility planning officers within HSPU/RDU who will lead the translation of the HPU Briefs to the PC during the Design Validation phase, and then join the RDU Commissioning team to take the project seamlessly through the design and construction phases.

19. The Principal Consultant will be secretariat to the ERGs, however the Facility Planning/Commissioning Officers from Service & Capital Planning Branch will assume responsibility for briefing the Project ERG about significant issues for decision.

20. HSPU will also take a role in project milestone evaluations of the PCs project deliverables throughout its progress to ensure that design, construction and commissioning processes are consistent with the planned scope.

21. It is proposed that in relation to the Building 3&2 project
    a) the Project Management function report through the HIP Program & Construction Director to the Director Redevelopment Unit for the management of the project, technical advice, engineering and facilities principles scope, and commissioning for the project during Design and Construction phases.
    b) that HSPU provide a facility planning function including updating and validation of information contained in HPU Briefs and translating requirements between the PC and stakeholders during the Design Validation phase. This will include briefing the Project ERG and other ERGs about issues that require decision related to that function.
    c) Shared Services Procurement undertake the procurement and contract management processes in consultation with the Project Manager.
    d) The commissioning and related project managers in RDU provide advice and input to the project as requested by the Project Manager.

Recommendations

That you:

- Agree to the implementation of the framework for the management of the building 3 & 2 project as articulated in Attachment A.

  AGREED/NOT AGREED/NOTED/PLEASE DISCUSS

- Endorse the proposal of Shared Services Procurement to procure the services of a Project Manager, Design for the project

  AGREED/NOT AGREED/NOTED/PLEASE DISCUSS

- Note that a recommendation will be forwarded to you by the Director Redevelopment Unit following further discussions between Health Services Planning Unit, Redevelopment Unit and Shared Services Procurement about the Technical Advisory framework for the project.

  AGREED/NOT AGREED/NOTED/PLEASE DISCUSS

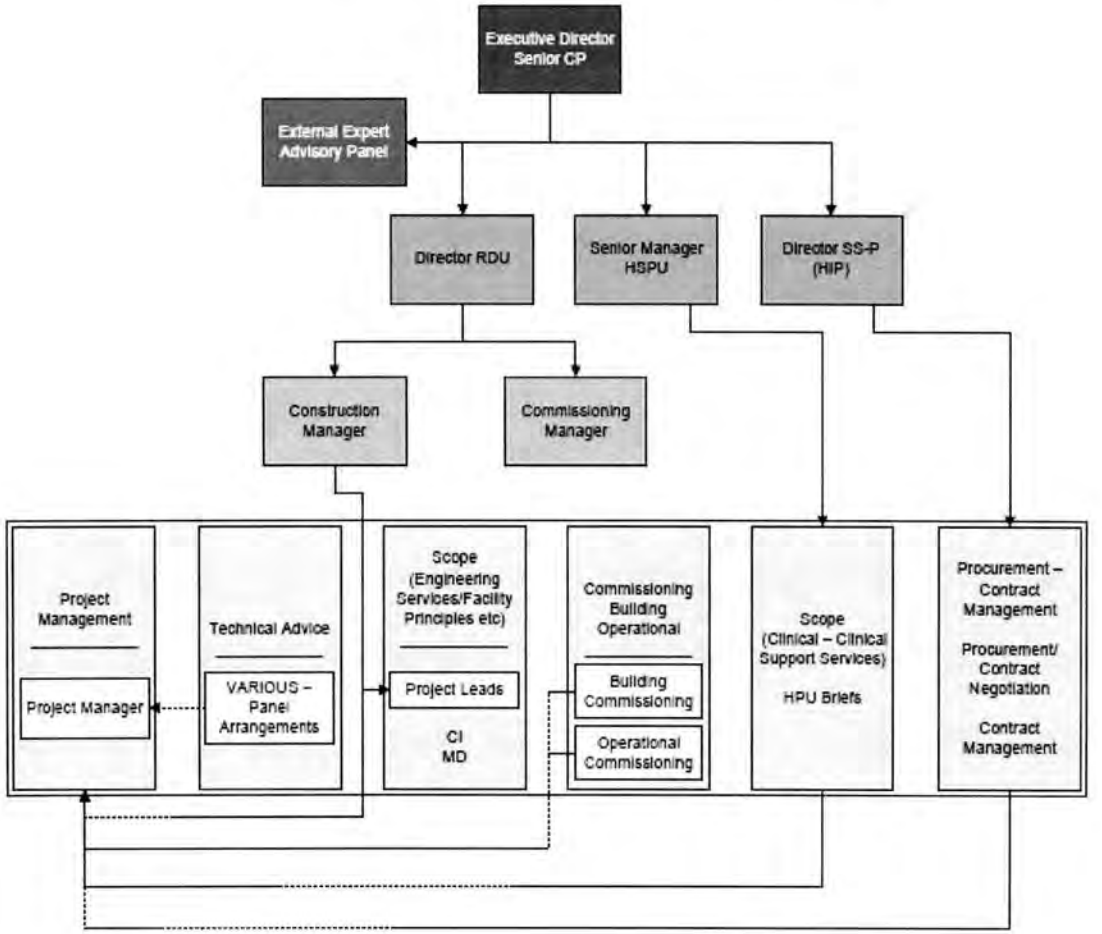
Name Jacinta George
Title Senior Manager, Health Services Planning Unit
Branch Service & Capital Planning

ACT Government
Health

MINUTE

Attachment A

Building 3.2 Project Management Framework



ACT Government
Health

Attachment

SUBJECT: Building 3, 2 Project Management Framework

To: Grant Carey-Ide, Executive Director, Service and Capital Planning

Through: Adrian Scott, Director, Redevelopment Unit

From: Jacinta George, Senior Manager Health Services Planning Unit

Date: ~~26~~ November 2012

Purpose

1. To propose a framework for the management of the Building 3, 2 project within Service & Capital Planning Branch.

Background/Issues

2. The complexity of the Building 3, 2 project was discussed at the Executive Planning Day on 10 September and you requested a proposal about the framework within which the project should be managed within the Branch.

3. The project will commence the Design (Project Validation) phase on appointment of the Principal Consultant (PC) and move into Preliminary Sketch Plan and Final Sketch Plan stages thereafter, subject to approvals.

4. Construction funding has not yet been appropriated.

5. Health Services Planning Unit (HSPU) has been working with stakeholders to update the Health Planning Unit (HPU) Briefs relevant to new Building 3, 2 incorporated in the Project Definition Plan (PDP) for HIP.

6. Redevelopment Unit (RDU) has been managing a number of projects that also form the basis of the PDP for this project, such as the Master Documentation Library, Campus Infrastructure and Staging and Decanting projects.

7. The previous Project Director, Thinc developed the Services Brief and Design Brief for the procurement of the PC, incorporating feedback from Shared Services Procurement (SS-P) and Redevelopment Unit (RDU).

8. A Project Director Meeting for this project was coordinated by Thinc as Project Director. The meeting included representation from Shared Services-Procurement, Director Redevelopment Unit, Senior Manager Health Services Planning Unit, Design Manager, Construction Manager and other key Redevelopment Unit staff. The Senior Manager HSPU has assumed the Chair and organisation of the meetings, until such time as it is coordinated by RDU, to ensure continuity until the governance arrangements for this project are finalised.

9. Shared Services Procurement has lead the procurement and contract negotiation processes for the appointment of the Principal Consultant.

10. A technical advisory role to HSPU/RDU as Design Manager, responsible for has been established and Thinc Health has been appointed (Saurabh Bhandari) to undertake that role until December 2012, pending agreement on the management framework for the project.

11. This role is responsible for providing proactive strategic advice to the Senior Manager HSPU and Director RDU on effective processes for client input and review during the design process, to ensure that relevant client documentation is available and considered by the PC, and that the design outcome aligns with project scope.

12. SSP has proposed to you the appointment of a Design Project Officer from a Panel Contract for Project Directors/Superintendents (Hospital/Health) Services. This position would manage the project through the Design phase including management of budget and program and be responsible for the management and resolution of design issues. This role differs from that contracted to Thinc (#10 above) in that it is a management rather than technical advisory role.

13. You have requested (PDR 73 response) that the details of the Technical Advisory function for the project be agreed and recommended to you. This will include a recommendation on the appointment of an External Expert Advisory Panel similar to or the same as those used by NSW Health Infrastructure "Four Wise Men".

14. The HIP Program & Construction Director and SS-P have recommended that an additional review of the documentation available to inform the design of Building 3, 2 be undertaken in addition to the advice being provided by Saurabh Bhandari. I have accepted the advice of the Construction Manager that a further external review (in addition to the previous role of Thinc as Project Director and as Design Manager, and the role that the PC will play during the validation period) will provide a value-for-money further level of

assurance about preparedness for the design phase. This review can be procured from the Health Services Planning Panel Contract. A procurement process is underway to have personnel in place by end November 2012.

15. Consideration is being given to the role of Design Manager across HIP.

16. The facility planning role of Health Services Planning Unit and the management of the design and construction phases through Redevelopment Unit will merge at the point of appointment of the Principal Consultant.

17. The Design phase of HIP projects has historically been a responsibility of RDU. It is recognised that HSPU has an ongoing role in ensuring that the design phase remains consistent with the HPU Briefs and underpinning assumptions. You have indicated that you are reviewing this structure.

18. A number of process improvements have been implemented recently to ensure continuity and consistency of planning through to design and construction. These include the planned co-location of the HSPU and RDU/SS-P teams, and the appointment of facility planning officers within HSPU/RDU who will lead the translation of the HPU Briefs to the PC during the Design Validation phase, and then join the RDU Commissioning team to take the project seamlessly through the design and construction phases.

19. The Principal Consultant will be secretariat to the ERGs, however the Facility Planning/Commissioning Officers from Service & Capital Planning Branch will assume responsibility for briefing the Project ERG about significant issues for decision.

20. HSPU will also take a role in project milestone evaluations of the PCs project deliverables throughout its progress to ensure that design, construction and commissioning processes are consistent with the planned scope.

21. It is proposed that in relation to the Building 3, 2 project

a) the Project ~~Management~~ Officer function report through the HIP Program & Construction Director to the Director Redevelopment Unit for the management of the project, technical advice, engineering and facilities principles scope, and commissioning for the project during Design and Construction phases.

~~a)~~b) That two positions be created; a Design Manager (DM) and a Building Services Design Manager (BSDM) that report to the Project Officer. The Project Officer will be supported by a Technical Advisory Panel who will be made up of a list of specialist contractors.....

Commented [gb1]: Supported??

Commented [gb2]: Where is the rest?

~~b)~~c) that HSPU provide a facility planning function including updating and validation of information contained in HPU Briefs and translating requirements between the PC and stakeholders during the Design Validation phase. This will include briefing the Project ERG and other ERGs about issues that require decision related to that function.

~~c)~~d) Shared Services Procurement undertake the procurement and contract management processes in consultation with the Project Manager.

~~d)~~e) The commissioning and related project managers in RDU provide advice and input to the project as requested by the Project ~~Manager~~Officer.

Recommendations

That you:

- Note the information contained in this minute;
  AGREED/NOT AGREED/NOTED/PLEASE DISCUSS

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- Agree to the implementation of the framework for the management of the Building 3, 2 project as articulated in Attachment A.
  AGREED/NOT AGREED/NOTED/PLEASE DISCUSS

- Endorse the proposal of Shared Services Procurement to procure the services of a Project Officer for the project
  AGREED/NOT AGREED/NOTED/PLEASE DISCUSS

~~1.~~• Agree to the creation of two new positions of Design Manager and Building Services Design Manager.
AGREED/NOT AGREED/NOTED/PLEASE DISCUSS

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~~2.~~• Agree that a Technical Adviser Panel be established.
AGREED/NOT AGREED/NOTED/PLEASE DISCUSS

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Grant Carey-Ide

Executive Director,
Service and Capital Planning

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~~November~~November 2012

Jacinta George
Senior Manager, Health Services Planning Unit
Extension: 50525

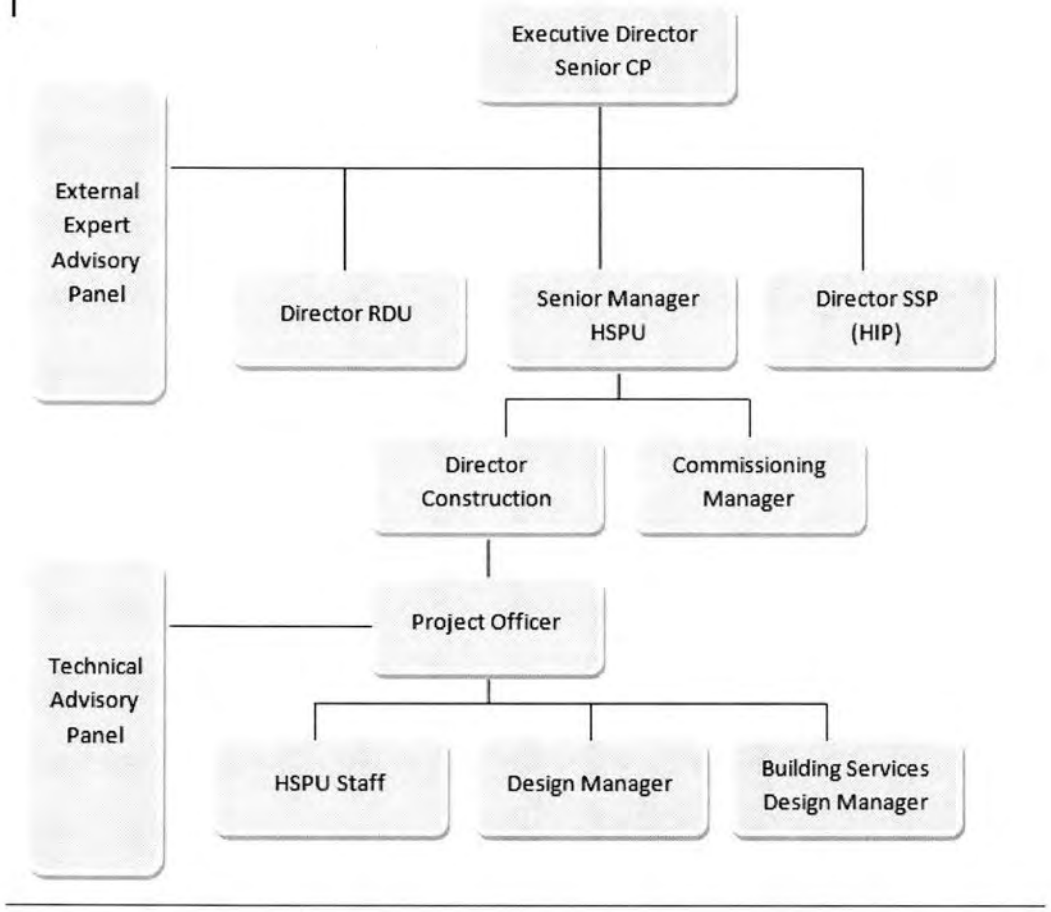
Jon Barnes
Director, Construction
Extension: 52135

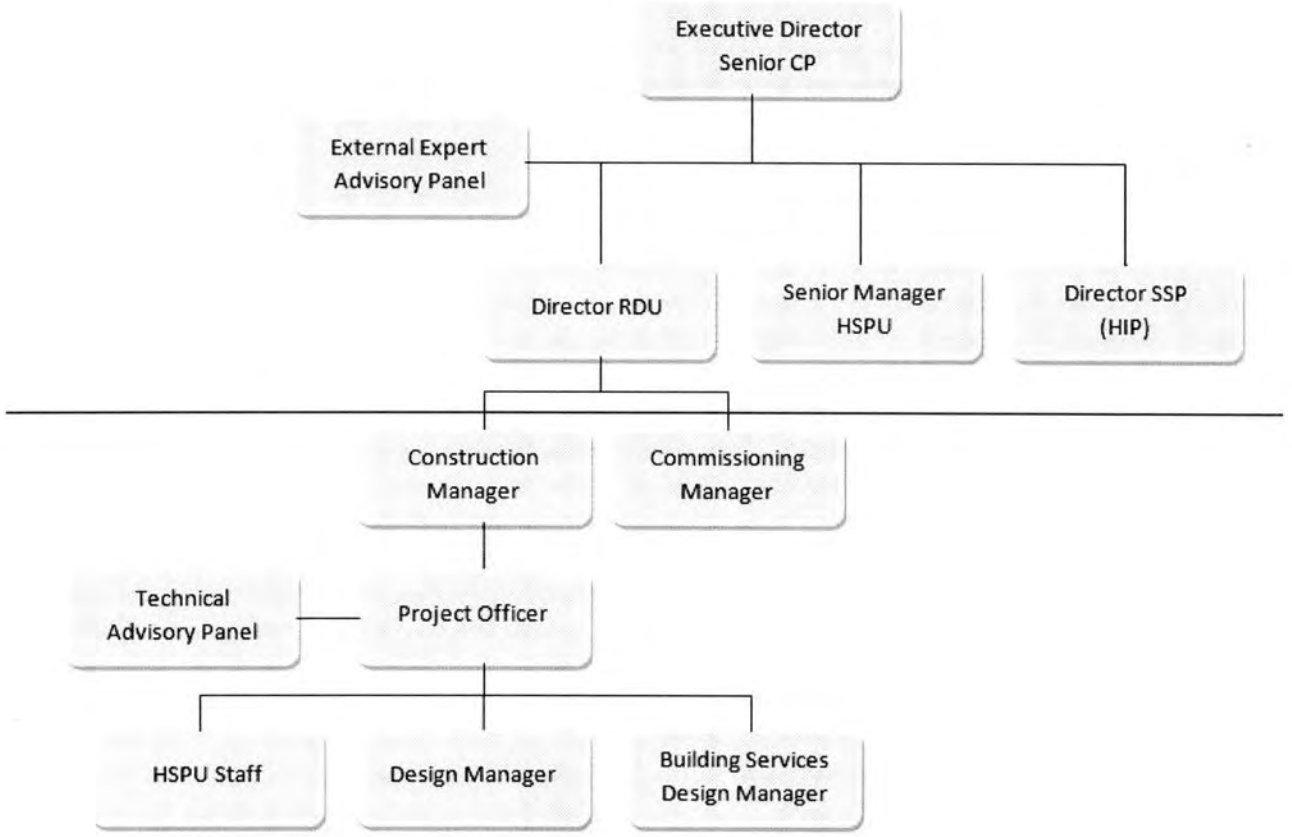
Adrian Scott
Director, Redevelopment Unit
Extension: 73088

ACT Government
Health

Building 3,2 Project Management Framework

Attachment 1




Executive Director
Senior CP
External Expert
Advisory Panel
Director RDU
Senior Manager
HSPU
Director SSP
(HIP)
Construction
Manager
Commissioning
Manager
Technical
Advisory Panel
Project Officer
HSPU Staff
Design Manager
Building Services
Design Manager

ACT Government
Health

MINUTE

SUBJECT: **Canberra Hospital Emergency Department Treatment Spaces – Health Infrastructure Program New Building 3 Health Planning Unit Brief, Request for Additional Information**

To: Dr Peggy Brown, Director-General

Through: Stephen Goggs, A/Deputy Director-General, Strategy & Corporate
Ian Thompson, Deputy Director-General, Canberra Hospital and Health Services

From: Grant Carey-Ide, Executive Director, Service & Capital Planning

Date: 15 January 2013

Purpose

To provide additional information, as requested, in relation the Health Planning Unit Brief for the TCH Emergency Department.

Background

1. COR12/13663, (18 December 2012) outlined the service planning methodology and consultation in relation to the future treatment spaces for the TCH Emergency Department, which you noted.

2. The brief also detailed the number of functional spaces required to inform the Health Planning Unit Brief with a recommendation that expansion space be designed in such a way that the Emergency Department can easily expand as necessary. You requested further information in relation to this recommendation.

    a. What level of drainage from north Canberra to TCH is provided for in the model? Do we know whether this relates specific clinical areas e.g. women & children, caner, eyes etc.?

    b. Why is there such a discrepancy between the jurisdictional models and have they adjusted them in any way to accommodate the four hour rule? What effect has the four hour rule had on our demand?

    c. How many spaces currently?

    d. Do the current spaces include paediatrics? If so, will the Paediatric Stream (election commitment) add to the current numbers and/or to the number we are proposing to deliver in 2013?

Issues – Refer to Attachment A

North side resident flows to TCH

3. Table 1 presents the output of the ED projection model.

4. Of the approximately 57,000 north side resident attendances to ACT emergency departments in 2010/11, approximately 12,000 (21.5%) of these attendances were made at TCH.

5. The model assumes that of the approximately 104,000 attendances projected for north side residents in the future, the same % will present to TCH and therefore the approximately 12,000 attendances would grow to 22,500 by 2021/22.

6. Broad comparison of north side resident emergency department attendances at TCH and CH provides a few observations:
    - Table 2 - that the proportion of paediatric attendances at TCH is higher (27%) than CH (19%).
    - Table 3 - that the proportion of attendances triage category 1-3 at TCH is higher (45%) than CH (37%).
    - Tables 4 & 5 – that the proportion of admissions from ED is higher at TCH (33%) than CH (12%). The high volume admissions to inpatient wards from ED at TCH include paediatrics, mental health, surgical/procedural type wards.
    - This suggests there is a degree of specialisation of the north side resident presentations to TCH (availability of paediatric inpatient services, emergency surgical services, cardiac catheterisation). However, when analysing volumes, clearly on average for this resident group, at least twice the demand is being met at CH compared with TCH.

7. In an emergency, specialisation or patient choice tends to play less of a factor in where patients present. The exception to this would be where Ambulance services triaging to hospitals as appropriate. The priority, generally, will be accessing the closest service and we can see this in Table 1 where nearly 80% north side resident emergency department attendances are presenting to CH and nearly 95% of south side resident emergency department attendances are presenting to TCH.

8. The model assumes that the current profile of north side residents at TCH ED will continue in the future and will grow in line with geographical population projections plus an additional three per cent.

Variance in Jurisdictional Models and Four Hour Rule Implications

9. The discrepancy between the various jurisdictions' models partially relates to the date when the models were last updated/reviewed and the fact that ED models of service delivery and the policy environment has changed over recent times.

10. The Queensland model, the most recently developed of the jurisdictions, has a higher level of sophistication in its modelling and does factor in the four hour rule.

11. Table 6 compares the models and the number of patients per space per day assumed (based on ACT ED attendance profile) and when these models were last reviewed.

12. The NSW Ministry of Health is about to commence an update of the Activity Planning Guidelines for Emergency Department Services in NSW. The Health Services Planning Unit is liaising with the appropriate Ministry staff to identify opportunities for us to collaborate in the NSW update so that the update might also confirm ACT planning directions.

13. The implication of the four hour rule is that the turnover rate per space would be 5.4 patients per day. The ACT recommended model (that has informed the Health Planning Unit Brief) is 3.7 patients per day and is therefore conservative.

14. The ACT's performance in relation to the four hour rule is well short of the future target of 90%. For the calendar year 2012 only 57% of ACT ED attendances were either discharged or admitted within the four hour time frame[1].

15. It is also interesting to note that the current turnover per space at TCH is in the order of 7 patients per space per day (61,000 attendances, 35 spaces), certainly supporting the pressure that ED clinicians have been under.

Current Spaces and Implications of Election Commitment for Paediatric Stream

16. Table 7 presents a comparison of current and planned future emergency department functional areas at TCH.

17. Of the current 35 assessment spaces, 6 assessment spaces are designated for paediatrics.

18. The Paediatric Stream funding will be used to improve flows and segregation within the existing Emergency Department. At this stage of the planning, it is not anticipated that the funding will allow for an increase the number of paediatric assessment/treatment spaces.

---

[1] Advice from P&I Branch 16 January 2013

Recommendations

That you:

- Note the information above.

AGREED/NOT AGREED/NOTED/PLEASE DISCUSS

- Note that the Health Infrastructure Program will continue to brief the future Emergency Department at TCH with the functional spaces outlined in Table 7, but with expansion space designed in such a way that the Emergency Department can easily expand as necessary.

AGREED/NOT AGREED/NOTED/PLEASE DISCUSS

.....

Dr Peggy Brown MBBS (Hons) FRANZCP
Director-General
January 2013

Action Officer:	Jacinta George
Unit:	Health Services Planning Unit
Extension:	50525

Attachment A

Table 1: Output from ED projection model - ED attendances

Place of residence	Calvary Public Hospital			The Canberra Hospital			ACT Supply			% TCH share of Supply		% CH share of Supply	
	2010/11	2021/22 pop+ 3%	*av change pa*	2010/11	2021/22 pop+ 3%	*av change pa*	2010/11	2021/22 pop+ 3%	*av change pa*	*2010/11*	*2021/22 pop+ 3%*	*2010/11*	*2021/22 pop+ 3%*
ACT - South	2,199	3,029	*3.0%*	37,840	53,408	*3.2%*	40,039	56,438	*3.2%*	*94.5%*	*94.6%*	*5.5%*	*5.4%*
ACT - North	44,385	81,626	*5.7%*	12,170	22,491	*5.7%*	56,555	104,117	*5.7%*	*21.5%*	*21.6%*	*78.5%*	*78.4%*
ACT Balance	902	1,465	*4.5%*	1,192	1,930	*4.5%*	2,094	3,395	*4.5%*	*56.9%*	*56.8%*	*43.1%*	*43.2%*
SLHD	2,141	3,369	*4.2%*	6,996	11,141	*4.3%*	9,137	14,511	*4.3%*	*76.6%*	*76.8%*	*23.4%*	*23.2%*
NSW Balance + Other Interstate	1,737	2,680	*4.0%*	2,674	4,160	*4.1%*	4,411	6,841	*4.1%*	*60.6%*	*60.8%*	*39.4%*	*39.2%*
Total	51,364	92,170	*5.5%*	60,872	93,130	*3.9%*	112,236	185,300	*4.7%*	*54.2%*	*50.3%*	*45.8%*	*49.7%*

% Attendances by place of residence						
ACT - South	*4%*	*3%*	*62%*	*57%*	*36%*	*30%*
ACT - North	*86%*	*89%*	*20%*	*24%*	*50%*	*56%*
ACT Balance	*2%*	*2%*	*2%*	*2%*	*2%*	*2%*
SLHD	*4%*	*4%*	*11%*	*12%*	*8%*	*8%*
NSW Balance + Other Interstate	*3%*	*3%*	*4%*	*4%*	*4%*	*4%*

Table 2: Output from ED projection model - ED attendances "North side" Residents

ACT - North by Age group	Calvary Public Hospital			The Canberra Hospital			ACT Supply			% TCH share of Supply		% CH share of Supply	
	2010/11	2021/22 pop+ 3%	*av change pa*	2010/11	2021/22 pop+ 3%	*av change pa*	2010/11	2021/22 pop+ 3%	*av change pa*	*2010/11*	*2021/22 pop+ 3%*	*2010/11*	*2021/22 pop+ 3%*
North 0-14	8,629	17,939	*6.9%*	3,337	6,937	*6.9%*	11,966	24,876	*6.9%*	*27.9%*	*27.9%*	*72.1%*	*72.1%*
North 15-44	20,678	34,359	*4.7%*	5,654	9,395	*4.7%*	26,332	43,753	*4.7%*	*21.5%*	*21.5%*	*78.5%*	*78.5%*
North 45-74	10,975	20,603	*5.9%*	2,413	4,530	*5.9%*	13,388	25,133	*5.9%*	*18.0%*	*18.0%*	*82.0%*	*82.0%*
North 75+	4,103	8,726	*7.1%*	766	1,629	*7.1%*	4,869	10,355	*7.1%*	*15.7%*	*15.7%*	*84.3%*	*84.3%*
Total	44,385	81,626	*5.7%*	12,170	22,491	*5.7%*	56,555	104,117	*5.7%*	*21.5%*	*21.6%*	*78.5%*	*78.4%*

% Attendances by Age Grp		
North 0-14	*19%*	*27%*
North 15-44	*47%*	*46%*
North 45-74	*25%*	*20%*
North 75+	*9%*	*6%*

Table 3: North side Resident ED attendances by Hospital by Triage Category 2010/11

Triage Category	CH	TCH	ACT Supply	% Supply CH	% Supply TCH	
1. Resuscitation - Immediate within seconds	106	82	188	*75%*	*25%*	*Triage 1-3*
2. Emergency <= 10 mins	2,814	1,483	4,297			
3.Urgent <= 30 mins	13,605	3,888	17,493			
4.Semi-urgent <= 60 mins	21,905	5,118	27,023	*81%*	*19%*	*Triage 4-5*
5.Non-Urgent <= 120 mins	5,955	1,599	7,554			
Total	44,385	12,170	56,555			
Triage 1-3	*37%*	*45%*				
Triage 4-5	*63%*	*55%*				

Table 4: North side resident ED attendances by Urgency, Disposition Group 2010/11 (EDIS)

Urgency, Disposition Group	CH	TCH	ACT Supply	% Supply CH	% Supply TCH
Admit	5,375	4,023	9,398	*63%*	*37%*
Dead On Arrival	3		3	*83%*	*17%*
Did Not Wait	3,884	1,312	5,196	*80%*	*20%*
Discharged	35,123	6,835	41,958	*81%*	*19%*
Total	44,385	12,170	56,555	*78%*	*22%*
% admitted	*12%*	*33%*	*17%*		

Table 5: North side resident admissions from TCH ED by ward 2010/11 (EDIS)

TCH Ward admitted to	Admissions	
Grand Total	4,023	*% of total*
EMU	952	*24%*
L4B (paediatrics)	691	*17%*
PSU (MH)	295	*7%*
2SA (SAPU)	201	*5%*
L7B (MAPU/Sort Stay)	184	*5%*
THE (Theatre)	153	*4%*
No ward specified	149	*4%*
11B (orthopaedics)	120	*3%*
L6B (Cardiac & Thoracic Surgery)	120	*3%*
Balance of Wards	*1,158*	*29%*

Table 6: Summary of Planning Model Throughputs and Dates of Last Review

Model/Jurisdiction	Average Pts per space/day	Last Reviewed
NEAT 4hr rule	**5.4**	
ACEM	3.0	2007
Qld	5.3	2010
Vic	3.3	2009
NSW	4.0	2006
ACT *	3.7	2011

* 30% fast track and 8.2 pts/space per day, balance at 3pts/space per day

Table 7: Comparison of Current and Future (HPU Brief Nov 2012) Functional Planning areas TCH ED

Core Service Units	2012	2021-22
Ambulance Bay	1 (3 parking spaces)	6 In addition, additional parking spaces will be required for overflow.
Resuscitation - adult	2	6
Resuscitation - paediatric	1 (suited for paeds and adults)	1
Paediatric holding bay	0	2
Acute assessment - adult	20 +1 negative pressure isolation	38 includes 4 isolation rooms
Acute assessment - paediatric	6	12 includes 2 isolation rooms
Fast track	5 (1 Patient Bay & 4 Annex beds)	8 Will accommodate up to 8 patients on beds or 14 with recliners instead of 5 bays
Consult rooms	3 (incl eye room)	5 Includes: 1 eye, 1 ENT/dental, 3 general
MHAU	6	6
EMU	9	25 (20 adult, 5 paed)
Treatment room	1 (plaster)	6 (includes 2 physiotherapy)
Procedure room	0	4
Medical imaging	0	3
Interview room	0	4
Clinical Forensic Medical Unit	0	1

Total Acute Assessment, Fast Track, Consult & Treatment Rooms	*35*	*69*

ACT Government
Health

HIP Project Request

HIP PR 194

SUBJECT: Termination of Principal Consultant (PC) procurement process for Building 3,2 & Associated Works project

To: Dr Peggy Brown, Director-General, Health Directorate

Through: Stephen Goggs, A/g Deputy Director-General, Strategy & Corporate

From: Grant Carey-Ide, Executive Director, Service and Capital Planning

Date: 8 May 2013

Purpose

To obtain your approval to terminate Building 3,2 and Associated Works PC procurement process

Background

2. Tender for engagement of a Principal Consultant (PC) was called in December 2011. Scope of work for the PC was to design replacement buildings for current Buildings 2 and 3.

3. A budget of $41M was appropriated in 2011/12 to cover a number of pre construction phase activities including this design consultancy.

4. Tenders closed for this project in February 2012.

5. Following a lengthy evaluation process a preferred PC was identified and Health DG approval to conduct pre contract negotiations was secured in late July 2012.

6. Negotiations with the preferred PC (PPC): [redacted] commenced in August 2012.

7. In December 2012, the Health Directorate requested that negotiations with the PPC be put on hold pending a review by Chief Minister's office of the project.

8. Following this review it was accepted that Building 3,2 and Associated Works project would be considerably different in scope compared with original plan that was market tested as part of current PC Procurement process.

9. ACT Government Solicitor (ACTGS) [redacted]

Issue

10. Tender validity for PPC proposal is due to expire on 10 May 2013 at 2.00pm.

11. ACTGS [redacted]

Funding

12. Not Applicable

Approval

Approval is sought to;

13. Agree to termination of current PC procurement process.

14. Sign and issue attached letter notifying PPC of Termination of Procurement process.

Recommendations

That you:

- Note the information contained in this HIP Project Request;

  AGREED/NOT AGREED/NOTED/PLEASE DISCUSS

- Approve Termination of Building 3,2 and Associated Works PC procurement process.

  AGREED/NOT AGREED/NOTED/PLEASE DISCUSS

- Signed attached letter notifying PPC of termination of procurement process for Building 3,2 and Associated Works PC project.

  AGREED/NOT AGREED/NOTED/PLEASE DISCUSS

Dr Peggy Brown MBBS (Hons) FRANZCP
Director-General
Health Directorate
May 2013

Grant Carey-Ide
Executive Director
Service and Capital Planning
May 2013

Action Officer: Ken Russell
Extension: 48098

Pond, Aleks (Health)

From: Brown, Peggy
Sent: Monday, 20 May 2013 8:42 AM
To: Elsey, Jennifer
Subject: FW: RFT 18158.110 Principal Consultant
Attachments: Termination of Procurement_130516.pdf

T/R

Dr Peggy Brown MB, BS (Hons) FRANZCP
Director-General

11 Moore St, Canberra City 2601
GPO Box 825, Canberra City
Phone: 02 6205 0825
Fax: 02 6205 0830
E-mail: **peggy.brown@act.gov.au**

Care ▲ Excellence ▲ Collaboration ▲ Integrity

ACT Government Health

From: [redacted]
Sent: Friday, 17 May 2013 7:20 AM
To: Brown, Peggy
Cc: [redacted]
Subject: RE: RFT 18158.110 Principal Consultant

Dr Brown,

Please find attached response to your letter of 10 May in relation to The Canberra Hospital.

Look forward to speaking to you about this further.

Regards,

[redacted]

From: Elsey, Jennifer [mailto:Jennifer.Elsey@act.gov.au] **On Behalf Of** Brown, Peggy
Sent: Friday, 10 May 2013 9:15 AM

To [redacted]
Subject: RFT 18158.110 Principal Consultant
Importance: High

Good morning – Please find attached correspondence regarding ACT Health's Health Infrastructure Program

Jenni Elsey
Senior Personal Assistant to Director-General
Dr Peggy Brown
Health Directorate

ACT Government
Health

T (02) 6205 0823 | F (02) 6205 0830
E jennifer.elsey@act.gov.au | W www.health.act.gov.au
Level 3, 11 Moore Street, Civic

Care ▲ Excellence ▲ Collaboration ▲ Integrity

[redacted]

16 May 2013

Director-General
ACT Health
GPO Box 825
Canberra ACT 2601

Attention: Dr Peggy Brown

Dear Peggy

Re: RFT 18158.110 Principal Consultant
Health Infrastructure Program (HIP, formerly CADP) – The Canberra Hospital (TCH) Redevelopment Stage 3: Building 3, 2 & Associated Works
Termination of Procurement

We acknowledge receipt of your letter of 9th May 2013 advising that the procurement process for the TCH Redevelopment Stage 3 was terminated. While we are obviously extremely disappointed with this development, we remain committed to working with ACT Health and supporting you in future planning and capital developments. We note we have since receipt of your letter we have submitted an Expression of Interest for the University of Canberra Public Hospital.

We would like to accept your offer to meet with the HD Executive to gain a better understanding of the project's likely direction, receive some feedback on our submission and particularly where we could improve our offering in the future, and identify any other opportunities where we may be able to assist you.

Please feel free to email or phone me on [redacted] to arrange a time over the next couple of weeks.

Yours faithfully

[redacted]

ACT Government
Health

[redacted]

Dear [redacted]

Health Infrastructure Program – Termination of Procurement for Redevelopment Stage 3: Building 3, 2 and Associated Works at Canberra Hospital

Thank you for your letter of 16 May 2013 regarding the termination of the procurement process for Redevelopment Stage 3 at Canberra Hospital.

While I am happy to accede to your request for a meeting, I suspect there is little light I can shed on your past tender performance.

Given that your company attained preferred tenderer status there is no feedback that could usefully be given about what was an impressive submission. Any comments would simply confirm the high quality of the submission in relation to the particular requirements of the Buildings 3, 2 process. Similarly, there is little ACT Health could suggest in relation to any future submissions, given that each tender process has discrete requirements. Future opportunities, including in relation to any reformulated concepts for Buildings 3, 2 and associated works, will be the subject of publicly issued documentation and therefore I could not identify "any other opportunities" as you hoped in your letter.

You also mentioned your submission of an expression of interest for another project being tendered as part of the Health Infrastructure Program. You will appreciate that in my position, I will not be able to comment in any way on the subject of tender processes that are in progress.

If you still wish to meet, notwithstanding these limitations please contact my office to arrange a convenient time when you are next planning to be in Canberra.

Yours sincerely

Dr Peggy Brown MBBS (Hons) FRANZCP
Director-General
ACT Health

June 2013

ACT Government
Health

Minute

SUBJECT: Project Director Start up Services - Building 2 / 3 Forward Design and Building 1, 10 and 12 Audits

To: Ian Thompson, A/g Director-General, ACT Health

Through: Ross O'Donoughue, A/g Deputy Director-General, Strategy and Corporate

From: Jacinta George, A/g Executive Director, Service and Capital Planning

Date: 11 December 2013

Purpose

To seek your approval for Shared Services Procurement (SSP) on behalf of ACT Health to procure a Project Director for the start up services – Building 2/3 Forward Design and Building 1, 10 and 12 Audits.

Background

In the 2013- 2014 Financial Year an appropriation of $40.78 Million was provided for Clinical Services and Inpatient Unit Design and Infrastructure Expansion (CSI-UDIE).

Of the above appropriation, some $ 20.87 million was provided for two separate services, being Building Audits for Building 1, 10 and 12 on the Canberra Hospital Campus and the progression of Proof of Concept and Forward Design to Preliminary Sketch Plan (PSP) for new buildings to replace the current Buildings 2 and 3 on the Canberra Hospital Campus.

The Building Audit study is programmed to commence in February 2014, and the Building 2/3 Proof of Concept is programmed to commence in April 2014. Both projects are extremely complex and will require a dedicated senior and experienced Project Director from within ACT Health.

Currently a dedicated person of this level of expertise does not exist within the Service and Capital Planning Branch. As a result there is an urgent need to appoint a dedicated Project Director to undertake the initial start up management and coordinating activities for this project.

In accordance with the current industry norm, the price/fee for Project Director Services would be at a contracted annual rate of $300,000 (plus annual indexation in accordance with CPI and GST exclusive).

The term of contract for Project Director start up services is six months.Considering the above term, the value of this procurement is under $200,000 threshold triggering a select tender process. . In accordance with this process, three selected consultants will be requested to submit their proposal for the Project Director services:

- Aurora Projects;
- Kazbar Holdings; and
- Xact Consulting.

The fee will be a lump sum fee and shall include all of the following:

- GST;
- All travel and accommodation and disbursements associated with this role;
- Cost of the consultant insurances required by the Territory; and
- Escalation.

The attached Procurement Plan Minute seeks your approval to commence this procurement via a select process for a person to fulfil the Project Director role for the start up services – Building 2/3 Forward Design and Building 1, 10 and 12 Audits (**Attachment A**).

Issues

N/A

Funding

To be advised.

Recommendations

That you:

- note the above information; and

NOTED/PLEASE DISCUSS

- give your approval for SSP to commence a procurement process to engage a Project Director for start up services – Building 2/3 Forward Design and Building 1, 10 and 12 Audit in accordance with the attached Procurement Plan Minute and supporting documentation.

NOTED/AGREED/DISAGREED/PLEASE DISCUSS

.....

Ian Thompson
A/g Director-General
December 2013

Jacinta George
A/g Executive Director
Service and Capital Planning
11 December 2013

Narelle Davis
A/g Director
Redevelopment Unit
HIP
November 2013

Colm Mooney
Shared Services Procurement
November 2013

Action Officer: Margaret Mialkowska
Ext 48023

Mialkowska, Margaret

From: Mooney, Colm
Sent: Wednesday, 5 March 2014 9:51 AM
To: Mialkowska, Margaret
Subject: FW: Additional scope of work Justin Barrett

As discussed

Colm

From: George, Jacinta (Health)
Sent: Wednesday, 19 February 2014 7:36 PM
To: Mooney, Colm
Cc: Barnes, Jon (Health)
Subject: Additional scope of work Justin Barrett

Colm

As discussed today, I've added to Justin's scope of work to include PD for the secure unit and also advice on CRCC PD report. The former ongoing for the period of his contract, As his contract was a 4 month for the brief for B3/2 then I think that this will mean a time extension to his contract ? by 2 months. The latter piece of work was completed within 2 days.

J

Jacinta George
Acting Executive Director
Service & Capital Planning
ACT Government Health Directorate
GPO Box 825
CANBERRA ACT 2601
(02) 62050907
[redacted]

ACT Government
Health

MINUTE

SUBJECT: Building 3 and 2 Investment Logic Workshop

To: Jacinta George, A/g Deputy Director-General Health Infrastructure and Planning

Through: Robyn Cross, A/g Senior Manager, Redevelopment Unit

From: Colm Mooney, Director, Shared Services Procurement HIP

Date: 08 April 2014

Purpose

To seek your agreement to appoint Ernst and Young to facilitate an Investment Logic Workshop (ILW) for the construction of the building 3/2 project.

Background

As part of The Capital Framework, an ILW is required to inform the business case for a project. After receiving three quotes for the facilitation of the ILW from the panel of Investment Logic Workshop Facilitators, Ernst and Young were chosen as the preferred given the scope and scale of the 3/2 project. The ILW is scheduled for the 30 April between 9.30am and 11.30am. Meeting invitations are currently being issued for the workshop. Attendance is required from key ACT Health Stakeholders.

The Ernst and Young proposal is for $2,545.00 plus disbursement costs with an upper limit of $1,000.00. The initial cost for this will be paid for in the project budget however this cost is reimbursed from Treasury. Shared Services Procurement have submitted the required forms to facilitate reimbursement.

Recommendations

That you:

- Note the information.

NOTED/PLEASE DISCUSS

- Agree that Ernst and Young be engaged to facilitate the Building 3/2 project ILW.

AGREED/NOT AGREED/NOTED/PLEASE DISCUSS

.....

Jacinta George
A/g Deputy Director-General
Health Infrastructure and Planning

Colm Mooney
Director
Shared Services Procurement HIP
April 2014

Robyn Cross
A/g Senior Manager
Redevelopment Unit
April 2014

Action Officer: Dylan Blom
Extension: 48021

ACT Government
Health

Minute

SUBJECT: Project Director, Health Infrastructure Program (HIP): Project Director for Clinical Unit Redevelopment Projects at the Canberra Hospital Selection and Engagement;
Project Director Start up Services – Building 2/3 Forward Design and Building 1, 10 and 12 Audits – Contract Variation

To: Dr Peggy Brown, Director-General, ACT Health

Through: Jon Barnes, A/g Deputy Director-General, Health Infrastructure and Planning

From: Robyn Cross, Senior Manager Redevelopment Unit

Date: 5 May 2014

Purpose

To seek your approval of the Procurement Plan Minute (Attachment A) for the selection and engagement of a Project Director; the Health Infrastructure program (HIP) for Clinical Unit Redevelopment Projects at the Canberra Hospital (CH); and

To seek your approval of the Procurement Variation Minute (Attachment B) to extend the current contract with Kazbar Holdings Pty Ltd, Project Director for Start-up Services, Building 2/3 Forward Design and Building 1, 10 and 12 Audits until the selection and engagement of a Project Director for Clinical Unit Redevelopment Projects at CH is completed. This contract extension allows for transition period and additional scope associated with the Project Director services for the Secure Mental Health Unit project.

Background

In the delivery of major clinical unit projects, it is recognised that specialist health project director services are required. An Executive Construction and Program Director (Jon Barnes), has been engaged to oversee the delivery of the HIP. To support this executive role, a Project Director will be appointed for Clinical Unit Redevelopment Projects for Canberra Hospital and Health Services (Secure Mental Health Unit, Building 2/3).

On 31 January 2014 (COR 14/1042), approval to engage interim project directors for the most critical on campus projects was granted to:

- Kazbar Holdings Pty Ltd – Project Director for Start-up Services, Building 2/3 Forward Design and Building 1, 10 and 12 Audits (engaged to 3 June 2014).

- Xact Project Consultants Pty Ltd –Project Director for Start-up Services – Staging and Decanting (engaged to 1 September 2014).

An open tender process, recommended for the selection and engagement of the Project Director for Clinical Unit Redevelopment Projects for CHHS is as follows:

Pre Tender Industry Information	12 April 2014
Request for tender advertised	17 May 2014
Request for Tender closes (30 day advertising period in accordance with Australian Free trade Agreement threshold requirements)	19 June 2014
Tender Evaluation	June/July 2014
Approval of Tender Evaluation Report	July 2014
Negotiations	July 2014
Contract Awarded	August 2014

It is estimated that this engagement will cost the Territory $300,000 GST exclusive on annual basis.

The anticipated term of engagement is three years with an option of two one year extensions.

The three year term estimate is $900,000, and the total five-year budget estimate is $1,500,000 GST exclusive.

Issues

The Project Director for CHHS Clinical Unit Development Projects should be engaged in late August 2014, and the current contract with Kazbar Holdings Pty Ltd will expire on 3 June 2014. It is therefore recommended that Kazbar's contract be extended by up to four months including a transition period. Kazbar's fees for services per month are $40,909.09 GST exclusive. It is also to be noted that Kazbar's contracted scope has increased at ACT Health request to include Project Director services for the Secure Mental Health Unit project. The total value of this Variation is $163,636.36 GST exclusive.

The approved funding for interim Project Directors comes from HIP Project Management Project, Cost Code 21313 for External Consultants – HIP Projects. Funding for long term Project Director for Clinical Unit Redevelopment Projects at CHHS and Kazbar's contract extension for up to four months would come from the same funding source.

Recommendations

That you:

- Note the above information.

NOTED/PLEASE DISCUSS

- Approve and sign the attached Procurement Plan Minute (Attachment A) for the selection and engagement of a Project Director for Clinical Unit Redevelopment Projects for CHHS.

AGREED/NOT AGREED/NOTED/PLEASE DISCUSS

- Approve and sign the attached Procurement Plan Variation (Attachment B) for extension of the current contract with Kazbar Holdings Pty Lt, Project Director, Start up Services Building 2/3 Forward Design and Building 1, 10 and 12 Audits until the selection and engagement of a Project Director for Clinical Unit Redevelopment Projects at the Canberra Hospital (CH) is completed. Approve the additional scope under Kazbar's current contract with the Territory as requested by ACT ~~Health.~~

AGREED/NOT AGREED/NOTED/PLEASE DISCUSS

.....

Dr Peggy Brown MBBS (Hons) FRANZCP
Director-General
9 May 2014

Robyn Cross
Senior Manager
Redevelopment Unit
Health Infrastructure and Planning

April 2014

Action Officer: Margaret Mialkowska
Unit: SSP HIP
Extension: 48023

ACT Government
Commerce and Works

Procurement Plan Minute

PROCUREMENT OVERVIEW	
To	Director General/Delegate
Name of Project	Project Director; Health Infrastructure Program (HIP), for Clinical Unit Redevelopment Projects for Canberra Hospital and Health Services (CHHS).
Purpose	This Procurement Plan Minute seeks your agreement to procure a Project Director to provide consultancy services for Clinical Unit Redevelopment Projects for Canberra Hospital and Health Services (CHHS).
Estimated value ($)	The estimated total value of this procurement over the proposed period of the contract (three years) is $990,000 GST inclusive ($330,000 per annum), with the option for two (2) extensions of one (1) year each. The total contract value over a five year period is anticipated to be approximately $1,650,000 GST inclusive.
Timing/urgency	An indicative timeframe for this procurement is as follows: Pre Tender Industry Information — 12 April 2014 RFT advertised — 17 May 2014 RFT Closes — 19 June 2014 (30 day advertising period in accordance with Australian Free Trade Agreement threshold requirements). Tender Evaluation — June/July 2014 Approval of Tender Evaluation Report — July 2014 Negotiations — July 2014 Contract Awarded — August 2014 Debrief Unsuccessful Tenderers — August 2014 (Note: timings are estimates and may change after the Procurement Plan is signed)
Tender Number	24538.110
Is Government Procurement Board sign off required?	No. The procurement is under the nominated threshold.
Is ACT Government Solicitor consultation required?	The ACT Government Solicitor provides legal and probity advice for all HIP projects as required and requested. This procurement will be conducted in accordance with the HIP Probity Plan.

PROCUREMENT REQUIREMENTS	
Objective or scope of works or services to be provided	In the delivery of the Health Infrastructure Program (HIP), it is recognised that specialist health project director services are required. An Executive Construction and Program Director (Jon Barnes), has been engaged to oversee the delivery of the HIP. To support this executive role, a Project Director will be appointed for Clinical Unit Redevelopment Projects at the Canberra Hospital. **For further details refer to Attachment A – Project Brief**
Type	Services
Funding	Project funding is approved against HIP cost code 21313 External Consultants HIP Projects.
Site	**Refer to Attachment A – Project Brief**
Consultation (including pre tender)	The Health Directorate Redevelopment Unit and the HIP Executive Construction and Program Director have been consulted during the preparation of this Procurement Plan.

PROCUREMENT RISK	
Risk	Refer to **Attachment C - Risk Plan and Matrix**

PROCUREMENT METHODOLOGY	
Description of the procurement method to be used	One open tender process using (ACTGS) Services (Consultant) Agreement (RFT Annexure Version – July 2013).
Evaluation	Refer to **Attachment D - Evaluation Plan**
Is this suitable to be a Social Procurement?	No. The specialist nature of the services in not suited to a Social Procurement process.

TENDER EVALUATION TEAM				
Name	1. Jack Chu	2. Jacinta George	3. Colm Mooney	4. Greg Hammond
Position	Chair	Member	Member	Member
Directorate	Commerce and Works	Health Directorate	Commerce and Works	Justice and Community Safety
Statement on team composition	All members of the Tender Evaluation Team (TET) have tertiary qualifications in design or construction discipline and/or extensive experience in the procurement and delivery of health and/or related infrastructure projects.			

CONTRACT MANAGEMENT	
Number of contracts	One Consultant Services Agreement.
Contract management	The contract will be managed by Shared Services Procurement.
Period of contract(s)	The contract period will be for three years with an option for two additional one year contract extensions subject to Health Directorate approval.

AUSTRALIAN FREE TRADE AGREEMENTS (FTAs)	
Does the AUSFTA / Australia-Chile FTA apply?	Yes, the procurement anticipated contract value is above the $573,000 goods and services threshold. Note that compliance with the AUSFTA will ensure compliance with the Australia-Chile FTA and all other Australian FTAs.

AUSTRALIAN GOVERNMENT FUNDING	
Is there Australian Government funding attached to this procurement?	No

EXEMPTIONS	
Exemption Type	No exemptions requested.

SHARED SERVICES PROCUREMENT RECOMMENDATION			
Project Officer	Margaret Mialkowska	**Signature and Date**	[redacted]
		Phone Number	(02) 61748023 28/4/14
Director / Executive Director	Colm Mooney	**Signature and Date**	[redacted] 28/4/14

AGENCY ENDORSEMENT			
Name	**Jacinta George**	**Phone Number**	
Position	A/g Deputy Director General, Health Infrastructure and Planning		
Signature	[redacted]	**Date**	2/5/14

DIRECTOR GENERAL/DELEGATE APPROVAL			
Name	**Dr Peggy Brown**		
Position	Director General, ACT Health/delegate		
Statement	The Procurement Plan and attachments are approved.		
Signature		**Date**	

Brief / Statement of Requirements for Project Director; Health Infrastructure Program (HIP), for Clinical Unit Redevelopment Projects for Canberra Hospital and Health Services (CHHS).

ACT Government Health Directorate (HD)

April 2014

Background – HIP Program

The ACT Health Directorate, Health Infrastructure Program (HIP) projects' list includes but is not limited to the following new projects which may require Project Director involvement:

1. Canberra Hospital Continuity of Services – Essential Infrastructure (COS-EI)
2. Emergency Department Paediatric Streaming (ED-PS)
3. Staging and Decanting Package (S&D)
4. Canberra Hospital Essential Works Infrastructure and Engineering (CHEWIE)
5. Building 2 & 3 (B2&3)
6. Signage and Way-finding
7. Adult Secure Mental Health Inpatient Unit (ASMHIU)

The current status of the above projects is reflected in the attached HIP Master Program which includes all current HD projects. **Attachment B.**

The estimated total capital cost (design and construction) of the above projects is over $1 billion.

Scope

The scope of the Project Director Service is to provide senior level management of the Clinical Unit Redevelopment Projects for Canberra Hospital and Health Services (CHHS) from inception through to completion of construction and operational commissioning of the facility.

The ACT Health Directorate seeks to appoint an individual person to undertake this role for a fixed term contract. The role will be a full time position and will operate from within the Redevelopment Unit located at the Canberra Hospital.

The position will report to the Executive Construction and Program Director and will in due course have a number of direct reports. The role will also involve liaison and negotiation with external Government agencies.

The scope of services for the Project Director will include but not be limited to the following:

- Act as the Health Directorates representative at all meetings and forums;
- Undertake the management of the appointment of consultants required to undertake any planning and design studies;
- Provide written briefs up to Minister level on the projects;
- Oversee and assist the Project Manager(s) to:

- manage the design and the delivery of milestone design submissions for approval by the ACT Health Directorate;
- manage the appointment of construction contractors and /or Project Companies required to procure the facilities;
- manage the project/s to program and provide monthly program reports;
- manage the projects within the defined project budget parameters;

- Manage direct Redevelopment Unit reports;
- Establish and maintain the risk register for the projects;
- In conjunction with Shared Services Procurement undertake the management of the construction contracts or project deeds during the construction of the facilities;
- Undertake the management of the operational commissioning of the facilities on completion, and
- Manage the post occupancy of the facilities.

Responsibilities

The following table reflects the list of Project Director Responsibilities. It will be included in the "*Consultant Services Agreement*" together with this Brief.

PROJECT DIRECTOR RESPONSIBILITIES
1. Management and coordination of the site investigation, planning, design and construction issues relating to the project (s).
2. Investigate, advise and provide recommendations on procurement methodology options for the project.
3. Maintenance of and compliance with governance structures and procedures as they relate to the project to ensure that the ACT Health Directorate's key objectives are achieved.
4. Oversee and assist the Project Manager(s) to ensure that the responsibilities and agreed project deliverables of the Project Manager are being met: a. Management of design and construction delivery to program and to approved budget. - Management of program reporting on the project(s). *Ensure and verify that the project program is maintained and ensure that monthly program reporting is undertaken by the Master Programmer through the Project Manager.* - Management of cost reporting on the project(s). *Ensure and verify that monthly cost management and cost reporting activities are undertaken by the Project Manager.* b. Management of the scope of the projects as identified in the Health Facility Planning Brief (HFPB) to ensure it is maintained throughout the projects. c. Management and resolution of design and construction issues related to the project(s). d. Management of the performance of consultants and contractors involved in the projects.

5. Provision of monthly written and verbal reports to standing approval committees within the ACT Health Directorate.
6. Establishment and maintenance of a Project Management Plan for the project(s).
7. In conjunction with SSP be responsible for the tendering and appointment of various consultants and contractors to undertake the project (s).
8. Regular formal reporting to the ACT Government Health Directorate Executive, and provision of written advice on ad hoc basis to the ACT Health Directorate Executive as required.

Time Duration and Location

The contract will be for a fixed term of three years with an option to renew for an additional two years (three years + one year + one year). It is a requirement that the successful person resides in Canberra for the duration of the term of the contract. The Project Director will initially be accommodated in offices of the Redevelopment Unit located at the Canberra Hospital, however the location may change during the course of the project.

Deliverables under contract

The deliverables required under the contract will include but not limited to the following:

- Provision of regular briefs up to Ministerial level on issue related to the on campus projects
- Written monthly status reports
- Production of regular updated projected cash flows for the projects
- Production of monthly cost to complete and financial cost reports for the projects
- Risk Register for the projects updated quarterly
- Production of monthly status programs for the projects

Key Performance Indicators

The following Key Performance Indicators (KPI) will apply to this position. Performance of the KPIs will be reviewed annually. Continuation within the role will depend on the successful fulfilment of these KPIs.

- Final Sketch Plan Design gross floor area to be within 10% of gross floor area of approved projects briefs (where applicable).
- Project Milestones within the master project program to be achieved within 10% of announced dates.
- Projects cost to be within 10 % of Final Sketch Plan budget.

Fee for Service

The fee for service is to be submitted as a lump sum annual fee inclusive of GST. The fee will be paid annually in twelve equal payments. The fee is to allow for all leave and public holidays. A maximum of four weeks annual leave is to be taken in any one year.

The fee will be subject to an annual escalation adjustment based on the ABS capital city weighted average CPI percentage rate current at the time of the adjustment.

The fee is to include all travel within the Territory, insurances and disbursements. Interstate travel and accommodation if required and approved will be at the Territory's cost.

The use of a workstation, a mobile phone and computer and printing facilities will be provided at no cost by the Territory.

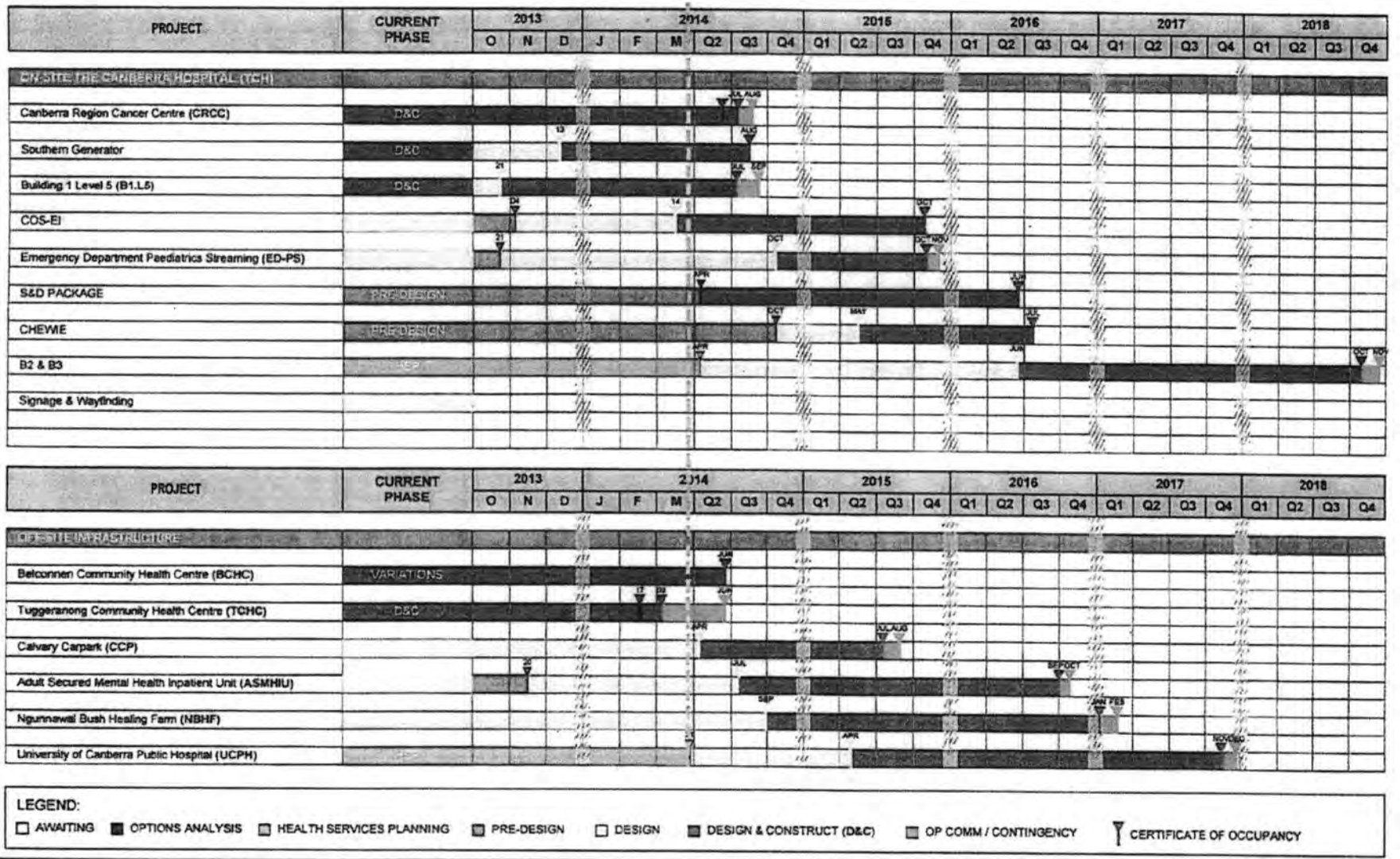
Attachment B

Solid Support — Delay Analysis — Delay Management Professionals

HIP MASTER PROGRAM
AS AT END MARCH 2014

ACT Government — Health

STATUS



LEGEND:
AWAITING | OPTIONS ANALYSIS | HEALTH SERVICES PLANNING | PRE-DESIGN | DESIGN | DESIGN & CONSTRUCT (D&C) | OP COMM / CONTINGENCY | CERTIFICATE OF OCCUPANCY

(Attachment B)

Attachment · Risk Plan and Matrix

RISK PLAN AND MATRIX

	CONSEQUENCES				
	Insignificant	**Minor**	**Moderate**	**Major**	**Catastrophic**
General	Negligible impact upon objectives	Minor effects that are easily remedied	Some objectives affected	Some important objectives cannot be achieved	Most objectives cannot be achieved
Community	Injuries or condition not requiring medical attention	Minor injury or First Aid Treatment needed	Serious injury needing hospitalisation, multiple medical treatment cases	Life threatening injuries, irreversible disability	Death/s, multiple life threatening injuries, irreversible disabilities
Property (including intangibles eg IT data & intellectual property)	Slight (non structural) damage or loss of public/ private goods, assets and data. Possible small compensation.	Minor (structural) damage or loss and liability for compensation	Significant damage or loss involving possible legal action for compensation	Serious damage or loss requiring operational changes involving legal action for significant compensation.	Extensive damage or loss, Business Continuity Plans activated, very heavy legal and compensation costs.
Financial	Possible unavoidable Expenditure resulting in Budgetary losses of up to 1% (or <$5K)	Up to 5% of budget (or <$50K)	Up to 20% of budget (or <500K)	Up to 40% of budget (or <$5M)	Greater than 40% of budget (or >$5M)
Environment	Negligible damage and loss of flora and fauna, degradation and/or loss of environmental amenity	Short term effects not affecting ecosystem functioning	Moderate environmental impacts, able to be contained and repaired in medium term	Long term environmental impairment of ecosystem functions	Widespread, long-term environmental impairment of more than one eco-system
Reputation	Minor adverse local attention, internal review	Attention from local media, scrutiny required by internal committees	Significant media attention, scrutiny required by external committee, Auditor General etc	Intense public, political and media scrutiny, damage to organisation	Assembly inquiry or Commission of inquiry, adverse national media

LIKELIHOOD						
Event is expected to occur in most circumstances	**Almost Certain**	**Medium**	**High**	**High**	**Very High**	**Very High**
Event will probably occur on most circumstances	**Likely**	**Medium**	**Medium**	**High**	**High**	**Very High**
Event may occur at some time	**Possible**	**Low**	**Medium**	**High**	**High**	**High**
Event is not expected to occur	**Unlikely**	**Low**	**Low**	**Medium**	**High**	**High**
Event is likely to occur only in exceptional circumstances	**Rare**	**Low**	**Low**	**Medium**	**Medium**	**High**

RISK MATRIX

(Attachment A.3)

Low Risk: Unlikely to require allocation of resources, manage by routine procedures.
Medium Risk: Must be brought to attention of manager, resources required to address risk must be allocated.
High Risk: Senior management action required, risk treatments applied. Responsibility must be specified. Subject to regular monitoring.
Very High Risk: Immediate action required. Senior executive attention needed with action plans and management responsibility specified. All possible treatments to be put in place to reduce risk.

Attachment · Risk Plan and Matrix

RISK REGISTER

Project: Project Director; The Health Infrastructure Program (HIP), for Clinical Unit Redevelopment projects at the Canberra Hospital (TCH)

Prepared by: Margaret Mialkowska Date: 22 April 2014 Reviewed by: Colm Mooney Date: 28 April 2014

Risk No	*The Risk (Cause) What can happen and how*	*Consequence Rating Describe the consequence*	*Likelihood Rating*	*Level of Risk Rating ** (refer Matrix)*	*Risk Priority Ranking*	*How are Risks to be Managed?*	*Consequence Rating after Treatment*	*Likelihood Rating after Treatment*	*Level of Risk Rating after Treatment*
Procurement Risks									
1.	***Unethical Tender Process – Inadequate tender & evaluation process; breach of probity***	*Minor* *Poor public perception* *Legal challenge to tender process*	*Unlikely* *Event is not expected to occur*	*Low*	*6*	*Pre-contract:* • *SSP to conduct a public open tender process in accordance with the HIP probity plan;* • *Tender Evaluation Team to conduct evaluation in accordance with the approved Procurement and tender Evaluation Plan;* • *Appoint experienced representatives on the Tender Evaluation Team;* • *Probity Advisor to be consulted as required.*	*Minor*	*Rare*	*Low*
2.	***Government objectives not achieved***	*Major* *Delivery of HIP Program compromised*	*Unlikely*	*High*	*1*	*Pre-contract:* • *Health Directorate to provide functional brief outlining scope of engagement;* • *Health Directorate to identify responsibilities and roles for the position* • *Health Directorate to identify position requirements / essentia*	*Major*	*Rare*	*Medium*

Attachment Risk Plan and Matrix

						criteria			
Service Risks									
3.	***Insufficient contract management effort***	*Moderate* *Substandard services*	*Unlikely*	*Medium*	*2*	*Pre-Contract:* • *HD to agree on KPIs for the contract* *Contract Period:* • *SSP to regularly monitor performance and expenditure of the contract*	*Moderate*	*Rare*	*Medium*
4.	***Continuation of Services - Annual Leave – Sick Leave***	*Minor* *No services during annual leave or personal/sick leave*	*Unlikely*	*Low*	*5*	*Pre-Contract:* • *HD to negotiate.* *Contract Period:* • *Implement and monitor contract provisions;*	*Insignificant*	*Rare*	*Low*
Programme Risks									
5.	***Project Procurement*** *Process - delays*	*Moderate* *Delays to On Campus projects.*	*Unlikely*	*Medium*	*4*	*Pre-contract:* • *Fast tracking of preparation of procurement documentation* • *Allow sufficient time for approvals of procurement documents* • *SSP to coordinate between Site Investigation, Commercial Advisor, Technical Advisor Panel and Project Director procurement programs.*	*Moderate*	*Rare*	*Medium*
Budget Risks									
6.	*Consultancy budget inadequate*	*Moderate* *Additional funding*	*Unlikely*	*Medium*	*3*	*Pre-Contract* • *Agree on a lump sum price for the term of the contract;* • *Agree on fixed scope*	*Minor*	*Unlikely*	*Low*

		required				*to include all current and future HIP Projects i.e. no variations permitted as it is essentially employment contract;* *Contract Period:* • *Agree on equal monthly payments for the duration of the contract;*			

Attachment C - Risk Plan and Matrix

Shared Services Procurement Risk Management Plan

Stakeholder Analysis

	Stakeholders – Internal and External Name and Agency/Organisation	**Stakeholders – Level of Influence** Ability to influence project outcome	**Stakeholder - Level of interest** Level of interest in the project outcome
R 1.	Minister for Health	Political support for project including funding, scope and timing of delivery	Very high
R 2.	Health Directorate – Services and Capital Planning	Responsible for advising Minister providing strategic direction on project delivery, governance structures, approval processes and business case cycle.	Very high
R 3.	Health Directorate Redevelopment Unit (RDU)	Responsible for coordination of project delivery including user groups, consultation, approvals, project scope and project brief	Very high
	Health Directorate – Health Planning Unit (HPU)	Responsible for the development of Health Planning Unit briefs, Models of Care and Project Definition plans, review of project against AHFG's.	Very high
R 4.	Health Directorate Hospital Staff existing	User Groups to inform development of project brief, Models of Care and design phase to FSP.	Very high
	Health Directorate Hospital Staff future	Limited direct influence – consideration of interest addressed by Health Planning Unit and RDU	Low
	Existing Health Services Consumers	Limited direct influence – consideration of interest addressed by HPU and RDU	Medium
	ACT Ambulance Services	Limited direct influence – consideration of interest addressed by HPU and RDU	High
	Local Residents	Local residents influence through media and minister regarding issues relating to but not limited to traffic, noise, light spill and visual amenity	Low - High
	Broader Community	Influence through media and minister regarding issues relating to but not limited to traffic, noise, light spill and visual amenity	Low - High

	Canberra and region community (existing and potential consumers)	Influence via media and minster regarding issues relating to but not limited to location, planning issues, equity of access, geographical access	Low - High
	Construction Industry	Influence in tendering, provision of value for money tenders, compliance with relevant legislative requirements including IRE, WHS and active prequalification. Delivery of quality outputs, supporting local economy and construction market.	Medium
	Territory and Municipal Services Directorate – ACT Roads, ACTION	Influence in relation to planning and design outcomes associated with transport including, vehicular, public transport and other transport networks including cycle and pedestrian	Medium
	Environment and Sustainable Development Directorate – Planning, Integrated Urban Waterways	Influence in relation to site and catchment planning in accordance with water sensitive urban design principles and integrated catchment management Influence in relation to planning and planning approvals process.	Medium
	Commerce and Works Directorate - Shared Services Procurement	Responsible for project delivery including procurement, budget, program, scope and quality	High
	Treasury Directorate	Responsible for budget appropriations	High

Attachment · Risk Plan and Matrix

PESTLE Analysis (Risks and Opportunities)		
POLITICAL	**ECONOMIC**	**SOCIO-CULTURAL**
Political factors the extent to which government policy affects the organisation's operations. Political factors include, tax policy, tariffs, trade restrictions and even environmental law. Engagement of HD executive steering committee required at early stages of the HIP new projects.	**Economic factors relates to areas such as inflation rate, interest rate, economic growth or exchange rates and how this impacts on the organisation.** Uncertain future economic climate may not be conducive to implementation of large health infrastructure. Significant health infrastructure projects have risks that require a contingency cost analysis. Risk Organiser analysis with input from the Client Representative, SSP, the Project Director and the HIP Master Cost Planner to fully analyse risks and costs associated with the project was undertaken on all new HIP projects.	**Social factors mainly refer to demographic factors, which comprise factors like population growth rate, cultural aspects, age distribution and health consciousness.** Risk associated with population and demographic projections required to inform the On project scope, program and budget. Significant piece of planning work required to inform the project delivery and feasibility. Community concern, lack of awareness or undertaking regarding the project. Communication strategy should be implemented to inform and educate the local and broader community and user groups regarding the proposal.
TECHNOLOGICAL	**LEGAL/LEGISLATION**	**ENVIRONMENTAL**
Technological factors refer to automation, incentives, the rate of technological change and R&D activity and how this affects business operations. Uncertainty regarding future technological developments in health care delivery. Requirement to investigate and make recommendations regarding future technologies, fit for purpose provision into the future.	**Legal factors refer to all the laws directly connected to a business/company and its area of activity, including consumer law, discrimination law and health and safety law.** Absence of prequalification requirement may generate negative feedback from industry. Exemption from industry briefing may generate negative feedback from industry. Non use of existing Territory Project Director Panel may generate negative feedback from industry.	**Environmental factors refer to weather, climate, geographical position and climate change.** Planning and environmental approvals will be required. Early site investigation work will need to identify potential environmental and site constraints issues to be further investigated for each individual project.

	However, given the specialist nature of the proposed services in a health facility context it may be appropriate to expand the scope for potential candidates by not restricting the field to prequalified entities (subject to managing risks associated with that approach) and to not engage from the existing panel. The intention to tender in early May 2014 for the PD services was announced in Canberra Times on Saturday, 12 April 2014 for the industry information. ACT GSO advice has been sought and will be sought on all probity and legal issues as required.	

Project Director; The Health Infrastructure Program (HIP), for Clinical Unit Redevelopment Projects at the Canberra Hospital (TCH)

Tender Assessment

Value for Money

In evaluating tenders, the Territory has as its objective the attainment of the best value for money and not the necessarily the lowest tender price.

Apart from the conformity with the requirements of the RFT, the Territory will evaluate tenders in accordance with the Evaluation Criteria comprising the Threshold Criteria and Weighted Criteria.

Evaluation Methodology

- Initially the Tender Evaluation Team (TET) will check the conformity with the requirements of the RFT.
- Apart from the conformity requirements, the TET will assess all tenders in accordance with the approved threshold and weighted criteria to establish a shortlist of tenderers to be interviewed.
- Initially, the TET will asses all tenders against the threshold criteria. Tenderers that do not meet the threshold criteria may be excluded from further consideration, subject to the decision of the TET. The TET may seek clarification from any tenderer to determine if they meet the threshold criteria. Tenderers that achieve the threshold criteria will be assessed against the weighted criteria.
- The assessment process for the weighted criteria requires the assignment of numerical rating scores against each criterion. Initially as individuals, each TET member will determine a score against the weighted criteria for each tender submission based on the information provided in the written material submitted at the close of tenders.
- Scores submitted by all TET members will be averaged to provide a consensus score result. If necessary, these scores will be rounded up or down to the nearest 0.5 figure (*eg: an averaged score of 7.4 will be rounded up to 7.5, whilst an averaged score of 6.2 will be rounded down to 6.0*). If required the TET will discuss the resulting criterion score and negotiate an adjustment. A final assessment score will be determined at the TET session.
- Tenderers will be required to obtain a score of 4 or above for each criterion or they may be excluded from further consideration in this tender assessment process.
- The declared evaluation criteria weighting (%) will be multiplied against the agreed/consensus numerical 1-10 score that each tender submission achieves against each weighted criterion.
- The aggregate scores will be combined to reach a 'total' assessment score for each tender submission.
- Each tenderer's 'total assessment score' will be ranked in order of highest to lowest.
- The four highest ranking tenderers will be invited to attend an interview with the TET. Tenderer interviews will be chaired by the TET Chair with opportunities for members of the TET to ask questions of the tenderers relating to their proposal. The shortlisted tenderers will receive the list of identical questions prior to their interview. The interviews will be fully

documented, and responses to questions may affect the tenderers' scores obtained prior to interviews.

- On completion of tender interviews, the TET will review the ratings of the shortlisted tenderers against the weighted criteria to establish the ranking of tenders from highest to lowest.
- The highest score identifies the submission providing the best value for money for the Territory and the preferred tenderer.
- The preferred tenderer will be recommended to the Delegate for award of the contract, subject to the outcome of any recommended contract negotiations identified in the Tender Evaluation Report.
- Post Tender negotiations will take place solely with the preferred tenderer until such time as either: (i) the tenderer withdraws their tender, (ii) the capacity to negotiate is exhausted, or (iii) the Territory decides to accept no Tenders and may elect to recall tenders.
- The TET is not obligated to accept any tenderer and may seek additional clarifications from the shortlisted tenderers prior to making a recommendation to the Delegate. The TET is authorised to seek in writing additional information, or clarification of tenders received where this information does not materially impact on the conformance of the tender. All clarification must be fully documented and appropriately filed.

Evaluation Criteria – Threshold Criteria

THRESHOLD CRITERIA	Yes/No
1. Demonstrates that the tenderer will be permanently located in the ACT for the period of contract.	Yes/No
2. Demonstrate that the tenderer accepts for the engagement, the price/fee for service within the current industry norm for Project Director Services at a contracted annual upper limit rate of $330,000 GST inclusive (plus annual indexation in accordance with CPI).	Yes/No
3. Tertiary qualification in a building or a construction related discipline with extensive work experience.	Yes/No

Assessment

Each threshold criterion will be assessed and rated in terms of risk to the Territory as set out below.

Rating	Description
Acceptable Risk (Yes)	The proposal represents a low or workable level of risk, typical of what the Territory would be expected to bear for this type of project.
Unacceptable Risk (No)	The proposal represents a level of risk higher than "acceptable risk", contains risks not present in other tenders would reasonably be anticipated to take longer than the specified time to complete, or pose a greater risk to achieving the specified quality.

Attachment - Evaluation Plan

Evaluation Criteria – Weighted Criteria

WEIGHTED CRITERIA	Weighting
1. Demonstrated experience in the management of the delivery of large to medium complex public health projects including related infrastructure from early definition to completion including design, construction, post completion and procurement process for hospital facilities delivery. Note: • Response must include brown-field environment project delivery examples. • Response is to include demonstrated experience in assessment and recommendation of design consultant and construction tenders. • Response must cite examples of tenderer's project involvement including responsibilities, deliverables, project values and referee contact details.	25%
2. Demonstrated skills and experience in management of consultants, contractors and stakeholders to achieve design and construction approvals within prescribed budgets. Note: • Response to include examples of tenderer's recent roles and responsibilities and strategies used for stakeholder, consultant and contractor management.	25%
3. Demonstrated experience in liaison with senior management and executive level on key issues. Be able to negotiate competing outcomes with various key stakeholders. Note: • Response is to include demonstrated experience in managing and dealing with inter government agencies.	20%
4. Demonstrated experience in the management of a range of design and construction contract types in the procurement and delivery of major hospital and infrastructure projects. Note: • Response is to include examples of experience in the management of various contracts including GC21 contract.	15%
5. Demonstrated experience in programming and program management, and the ability to drive design and capital works programs to meet client deadlines.	15%
Total Score	**100%**

Assessment

Each weighted criterion will be assessed and rated in terms of risk to the Territory as set out below.

Descriptor	Sample Commentary	Rating
Superior	Highly convincing and credible. Response demonstrates superior capability, capacity and experience relevant to, or understanding of, the requirements of the Evaluation Criterion. Comprehensively documented with all claims fully substantiated. Insignificant risk.	10
Outstanding	Highly convincing and credible. Response demonstrates outstanding capability, capacity and experience relevant to, or understanding of, the requirements of the Evaluation Criterion. Documentation provides complete details. All claims adequately demonstrated and substantiated. Insignificant risk.	9
Excellent	Response complies, is convincing and credible. Response demonstrates excellent capability, capacity and experience relevant to, or understanding of, the requirements of the Evaluation Criterion. Some minor lack of substantiation but the Tenderer's overall claim is supported. Low risk.	8
Very Good	Response complies, is convincing and credible. Response demonstrates very good capability, capacity and experience, relevant to, or understanding of, the requirements of the Evaluation Criterion. Minor uncertainties and shortcomings in the Tenderer's claims or documentation. Low risk.	7
Good	Response complies and is credible but not completely convincing. Response demonstrates adequate capability, capacity and experience, relevant to, or understanding of, the requirements of the Evaluation Criterion. Tenderer's claims have some gaps. Low risk.	6
Adequate	Response has minor omissions. Credible but barely convincing. Response demonstrates only a marginal capability, capacity and experience relevant to, or understanding of, the requirements of the Evaluation Criterion. Medium risk.	5
Reservations	Barely convincing. Response has shortcomings and deficiencies in demonstrating the Tenderer's capability, capacity and experience relevant to, or understanding of, the requirements of the Evaluation Criterion. Medium risk.	4
Poor	Unconvincing. Response has significant flaws in demonstrating the Tenderer's capability, capacity and experience relevant to, or understanding of, the requirements of the Evaluation Criterion. Medium risk.	3
Very Poor	Unconvincing. Response is significantly flawed and fundamental details are lacking. Minimal information has been provided to demonstrate the Tenderer's capability, capacity and experience relevant to, or understanding of, the requirements of the Evaluation Criterion. High risk.	2
Inadequate	Response is totally unconvincing and requirements have not been met. Response has inadequate information to demonstrate the Tenderer's capability, capacity and experience relevant to, or understanding of, the requirements of the Evaluation Criterion. High risk.	1
Not Acceptable	Tenderer was not evaluated as it did not provide any requested information and/or contravened nominated restrictions. High risk.	0

Fee for Services – Lump Sum

The fee for service is to be submitted as a lump sum annual fee inclusive of GST. It is not subject to weighting.

- The fee is to allow for all leave and public holidays. A maximum of four weeks annual leave is to be taken in any one year.
- The fee is to include all travel within the Territory, insurances and disbursements. Interstate travel and accommodation if required and approved will be at the Territory's cost.
- The fee will be subject to an annual escalation adjustment based on the ABS capital city weighted average CPI percentage rate current at the time of the adjustment.
- The use of a workstation, a mobile phone and computer and printing facilities will be provided at no cost by the Territory.
- The fee will be paid monthly in twelve equal payments.

REQUEST FOR TENDER NO. 24538.110

ACT Government

PROJECT DIRECTOR, HEALTH INFRASTRUCTURE PROGRAM (HIP),

FOR CLINICAL UNIT REDEVELOPMENT PROJECTS

FOR CANBERRA HOSPITAL AND HEALTH SERVICES (CHHS)

ON BEHALF OF HEALTH DIRECTORATE

CONTACT OFFICER: MARGARET MIALKOWSKA

SHARED SERVICES PROCUREMENT

PHONE: (02) 617 48023

EMAIL: margaret.mialkowska@act.gov.au

ISSUE DATE: 17 MAY 20114

CLOSING DATE: 19 JUNE 2014

CLOSING TIME: 2:00PM CANBERRA TIME

CONTENTS

1. STANDARD CONDITIONS OF TENDER

1.1.1. Tenderers must read this Request for Tender (RFT) in conjunction with the *Standard Conditions of Tender – Services* which Tenderers may download from Shared Services Procurement website at http://www.procurement.act.gov.au/home.

1.1.2. Any Special Conditions of Tender applying to this RFT are set out at section 5 of this RFT. Special Conditions take precedence over Standard Conditions of Tender to the extent of any inconsistency.

2. STATEMENT OF REQUIREMENTS

Refer to attached Project Brief / Scope of Requirements.

3. ASSESSMENT

3.1 Value for Money

3.1.1. In evaluating Tenders the Territory has as its objective the attainment of best value for money and not necessarily the lowest tendered price.

3.1.2. Apart from the conformity with the requirements of this RFT, the Territory will evaluate Tenders in accordance with the criteria outlined below.

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submission based on the information provided in the written material submitted at the close of tenders.

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3.5 Fee for Services – Lump Sum

The fee for service is to be submitted as a lump sum annual fee inclusive of GST. It is not subject to weighting.

- The fee is to allow for all leave and public holidays. A maximum of four weeks annual leave is to be taken in any one year.

- The fee is to include all travel within the Territory, insurances and disbursements. Interstate travel and accommodation if required and approved will be at the Territory's cost.
- The fee will be subject to an annual escalation adjustment based on the ABS capital city weighted average CPI percentage rate current at the time of the adjustment.

- The use of a workstation, a mobile phone and computer and printing facilities will be provided at no cost by the Territory.

- The fee will be paid monthly in twelve equal payments.

3.6 Assessment timetable

3.6.1. The proposed timetable for the procurement process relating to this RFT is:

RFT advertised	17/05/2014
RFT closes	19/06/2014
Contract awarded	August 2014
Debrief unsuccessful respondents	August 2014

4. CONTRACT REQUIREMENTS

4.1.1. The form of contract expected to be used for the Services required by this RFT is the Territory's *Services Agreement* which can be downloaded from the Shared Services Procurement website at http://www.procurement.act.gov.au. The Territory reserves the right to alter provisions of the contract and the form of contract if an alternative is determined to be more appropriate.

4.1.2. The contract is expected to be for an initial period of three years, with provision for up to one extension of two years. The maximum period of the contract will be five years.

4.1.3. Without limiting the insurance that is required to be held by the successful Tenderer by law (e.g. workers' compensation) or under contract with the Territory, the successful Tenderer will be required to take out and maintain:

(1) public liability insurance with coverage in the amount of not less than $10,000,000.00 in respect of each occurrence; and

(2) professional indemnity insurance with coverage in the amount of $1,000,000.00 in the annual aggregate.

5. SPECIAL CONDITIONS OF TENDER

5.1 Pricing and Two-Envelope Tender

Reserved

5.2 Panel of Consultants or Contractors

Reserved

5.3 Information Session

Reserved

5.4 Prequalification / Quality Assurance Requirements

There is no prequalification requirement for this RFT.

Quality Assurance Requirements:

For the Services to be provided under the ensuing contract, the minimum requirement of the Tenderer and/or its services is one or more of the following quality assurance criteria:

(1) quality assurance partial certification to ISO 9001:2008;

(2) professional association accreditation;

(3) certification by an approved industry association;

(4) professional qualifications relevant to the task; and/or

5.5 Qualifications, Training and Knowledge

5.5.1. The successful Tenderer will be required to ensure that all employees are adequately supervised to ensure that all Services are delivered in accordance with the requirements of the contract, and any relevant legislation and Australian Standard.

5.6 Electronic Lodgement of Tenders

Reserved

5.7 Compliance with Industrial Relations Employment and Obligations Strategy

Reserved

5.8 Existing Consultancies

The Territory advises prospective tenderers of the following appointments:

(1) Badgery Management Pty Ltd has been engaged as Project Director for the University of Canberra Public Hospital project, for the duration of that project;

(2) Xact Project Consultants Pty Ltd were engaged as a Program Risk and Systems Manager for all new projects associated with the Health Directorate's Health Infrastructure Program (HIP) between 4 September 2013 and 15 March 2014;

(3) Xact Project Consultants Pty Ltd have been engaged as Project Director for Start Up Services referable to Staging and Decanting for the period 15 March 2014 to 1 September 2014; and

(4) Kazbar Holdings Pty Ltd has been engaged as an interim Project Director for Start up Services, Building 2/3 Forward Design and Building 1, 10 and 12 Audits for the period from 3 February 2014 to 4 June 2014.

The Territory further advises that it may, in its absolute discretion, accept and assess tenders from one or more of the identified entities.

6. TENDERER DECLARATION

6.1.1. Tenderers must complete and submit with their Tenders the Tenderer Declaration in the form provided at Attachment 3 to this RFT. The Tenderer must be a legal entity and the "ACN" or "ABN" must accurately correlate with the legal entity.

6.1.2. Failure to submit the completed Declaration or to supply required information (unless information is specified by a Tenderer to be "Not Applicable") may render a Tender non-conforming.

6.1.3. If a Tenderer is a company, include ACN, and if a partnership or sole proprietor, include the full names of individual members and ABN.

7. LODGEMENT OF TENDERS

Tenders must be either posted or hand delivered by the closing time and date to:
The Tender Box
Entry Foyer, Macarthur House
12 Wattle Street
Lyneham ACT 2602

7.1.1. All enquiries in relation to this RFT must be directed in writing to the Contact Officer.

7.1.2. Below is a list of actions and/or information that Tenderers should review prior to submitting their Tender.

☐ Tender submitted on time

☐ Original and 3 copies submitted

☐ All Assessment Criteria addressed

☐ Completed and signed Tenderer Declaration

ATTACHMENT 1 – STATEMENT OF REQUIREMENTS

Refer to attached Project Brief / Statement of Requirements (Attachments A and B to this RFT)

ATTACHMENT 2 – PRICING SCHEDULE

Not used

ATTACHMENT 3 – TENDERER DECLARATION

I/We tender to the Territory for the Project Director, University of Canberra Public Hospital on behalf of the Health Directorate at the GST-inclusive prices specified in this Tender.

I/We have provided details of any information I/we wish to be treated as confidential in any resulting contract, in accordance with Part 11 of the *Standard Conditions of Tender – Services*.

I/We undertake to provide insurance policies if selected as the preferred tenderer prior to entering into a contract with the Territory.

I/We have sighted all addenda to this RFT.

Full Name and / or Name of Company AND/OR Trading Name *(Business Name)*

ACN (Australian Companies Number) OR ABN (Australian Business Number)

Business Address Postal Address

State P/Code State P/Code

Telephone No Mobile No Facsimile No Email address

Name of ACT Professional Standards Scheme Upper Limit of capped Professional Indemnity Liability Insurance

Tenderer's Representative (include telephone number)

Position Held by Tenderer's Representative

Signature of Director if corporation else Tenderer Printed Name

Date

Signature of 2nd Director if corporation else Witness Printed Name

ACT Government
Treasury

Procurement Plan (Variations)

VARIATION OVERVIEW			
To	Director-General/Delegate		
Purpose	This minute seeks your agreement to vary the contract for Kazbar Holdings Pty Ltd to include additional scope requested by Health Directorate and to allow for up to four months contract term extension until the open process for the selection and engagement of a Project Director; The Health Infrastructure program (HIP), for Clinical Unit Redevelopment Projects at the Canberra Hospital (TCH) is completed.		
Name of Contract	Health Infrastructure Program (HIP), Project Director Start up Services – Building 2/3 Forward Design (FD) and Buildings 1, 10 and 12 Audits.		
Contract Number	**2014.23743.110.01**	**Type of variation**	1. Increased scope 2. New contract period 3. New contract price
Estimated value of the variation ($)	The estimated value of this variation is $180,000 including GST ($163,636.36 GST exclusive). The original value of the contract was $180,000 (including GST). The estimated total value of this procurement over the proposed period of the contract, including funds already spent and funds expected to be spent under this variation, will be $$360,000 including GST ($327,272.72 GST exclusive).		
Anticipated Commencement Date	Anticipated commencement date for this variation is 5 June 2014 (the current contract term expires on 4 June 2014).		
Is Government Procurement Board (GPB) sign off required?	No.		

ORIGINAL PROJECT	
Background	The HIP Minute seeking HD approval of the Tender Evaluation Report recommendation for the engagement of Kazbar Holdings Pty Ltd to undertake the role of Project Director for Start up Services, Building 2/3 FD and Building 1, 10 and 12 Audits was approved by HD on 31 January 2014 (COR14/1042). On 19 February HD increased Kazbar's scope to include PD role for the Adult Secure Mental Health Inpatient Unit (ASMHIU) and also advice on CRCC PD report. The request for scope increase estimated additional two months to the contract term (to 4 August 2014). Refer **Attachment 1 to this PPV.**

	Considering the requirement for the PD services continuity on the above projects and the timeframe for the selection and engagement of a long term Project Director; The Health Infrastructure program (HIP), for Clinical Unit Redevelopment Projects at the Canberra Hospital (TCH) which should be completed by late August 2014, it is recommended that the current contract term with Kazbar Holdings Pty Ltd be extended up to four months to allow the PD services continuity and extra time for transition period involving transfer of responsibilities to the newly engaged long term PD.
Provision for variation	Clause 12.7 Variation (Consultant Agreement, General conditions): *"This Agreement may be varied or the Term extended only by the written agreement of the parties prior to the expiration of this Agreement.*
Key Performance Indicators under the contract	The up to date performance of Kazbar Holdings Pty Ltd is very good.

PERFORMANCE AND RISK	
Risk	This variation is recommended to mitigate the risk associated with the lack of PD services continuity until the open process for the long term PD is completed.

SHARED SERVICES PROCUREMENT RECOMMENDATION			
Project Officer	Margaret Mialkowska	**Phone Number**	6174 8023
Signature	[redacted]	**Date**	23/04/2014
Manager / Director	Colm Mooney	**Phone Number**	6174 8096
Signature	[redacted]	**Date**	28/4/2014.

AGENCY ENDORSEMENT			
Name	**Jacinta George**	**Phone Number**	
Position, Branch & Section	A/g Deputy Director General, Health Infrastructure and Planning		
Signature		**Date**	

CHIEF EXECUTIVE/DELEGATE APPROVAL			
Name	Dr Peggy Brown		
Position	Director General, ACT Health / Delegate		
Statement	Funding for this Variation Plan and attachments are approved.		
Signature		**Date**	

Attachment A

ACT Government
Health

COMPLETED

CORRESPONDENCE COVER SHEET

Correspondent: Carmody, Paul

Record Number: COR14/15437 DGC14/3047 **Date Due:** .....

Topic: Minute from Paul Carmody - Single Select Procurement for Commercial Advisor Services for the Completion of Building 3-2 Business Case

Action Required:

Draft Response	No	Info Only	No	Brief to Minister	No
Reply Directly	No	Action as Necessary	No	Comments to D-G	No
Brief to D-G	No	For Discussion	No	Coordinate Response	No
Action by Group	No	Advice	No	Full Speech	No
Ministerial Response	No				

Assignee: Finlay, India since 23/12/2014 at 9:18 AM

Comments for Cover Sheet:

Noted [redacted]
23/12/14

FILE

Dylan for Jo Lim
12/1/15

ACT Government Health

CORRESPONDENCE CLEARANCE

SUBJECT: Minute from Paul Carmody - Single Select Procurement for Commercial Advisor Services for the Completion of Building 3-2 Business Case

NUMBER: COR14/15437 **DATE DUE:**

Director-General - Health Directorate: Date: 23/12/14

Deputy Director-General, Strategy & Corporate: Date:

Deputy Director-General, Canberra Hospital& Health Services: Date:

Deputy Director-General, Health Infrastructure and Planning: [redacted] Date: 23/12/14.

Senior Manager, Executive Coordination: Date:

Senior Manager, Communications and Marketing: Date:

Chief Information Officer, E-Health & Clinical Records: Date:

Chief Finance Officer, Financial Management: Date:

Exec Director, Business and Infrastructure: Date:

Exec Director, Cancer, Ambulatory & Community Health Support: Date:

Chief Health Officer, Population Health: Date:

Exec Director, Critical Care: Date:

Exec Director, People, Strategy & Services: Date:

Exec Director, Medicine: Date:

Exec Director, Mental Health, Justice Health, Alcohol & Drug Services: Date:

Exec Director, Pathology: Date:

Exec Director, Performance Information: Date:

Exec Director, Policy & Government Relations: Date:

Exec Director, HealthCARE Improvement: Date:

Exec Director, Rehabilitation Aged & Community Care: Date:

Exec Director, Surgery, Oral Health & Medical Imaging: Date:

Exec Director, Women Youth & Children: Date:

Manager, Canberra Hospital Foundation: Date:

Director, Donate Life ACT: Date:

Exec Director, Clinical Support Services: Da te:

Professional Leads: Date:

Other: Date:

ACT Government
Health

Minute

SUBJECT: Single Select Procurement for Commercial Advisor Services for the completion of Building 3/2 Business Case

To: Dr Peggy Brown, Director-General, ACT Health

Through: Paul Carmody, Deputy Director-General, Health Infrastructure and Planning

Recommendations supported [redacted] 23/12/14.

From: Colm Mooney, Director, Procurement and Capital Works, Health Infrastructure

Date: 23 December 2014

Purpose

To seek your approval for exemption from the requirement to undertake a public tender process to engage a Commercial Advisor (CA) to develop a business case for Canberra Hospital Building 3/2 redevelopment.

Background

A Project Concept Brief regarding the proposed Canberra Hospital 3/2 Redevelopment ('Building 3/2 redevelopment') was submitted for Budget Cabinet consideration on the 9 November 2014. Within the Project Concept Brief it was noted that cash flow was projected from 2016-17, however appropriation was required in 2015-16 to enable contracts to be entered into within the same financial year.

[redacted]

Under the ACT Government Capital Framework, the Building 3/2 redevelopment is a Tier 3 project. Requirements of the framework that have been met to date include an Investment Logic Workshop, with an Investment Logic Map arising from this, and an Early Project Overview.

Issues

Given the scope and complexity of the Building 3/2 redevelopment, a number of meetings have been held with representatives of Chief Minister, Treasury and Economic Development Directorate regarding the project. The meetings identified the preferred approach for the preparation of the business case for the project was to prepare a full business case by 30 June 2015 for the Government to consider in late 2015.

[redacted] This decision significantly reduced the time for this work to occur. The first key activity is to engage a suitably qualified Commercial Advisor to prepare the business case.

Having reviewed companies listed on the ACT Government's Commercial Advisor Panel, and following discussions with the Infrastructure, Finance and Advisory Division (IFAD) of Treasury, a request for proposal (RFP) was issued to KPMG. The RFP documentation was jointly prepared by ACT Health and IFAD. A response, received 22 December 2014, is at Attachment A.

The ACT Government's *Government Procurement Regulation 2007* states that the Territory "must seek at least 3 written quotations from suppliers for the procurement of goods, services or works if the total estimated value of the procurement is $25 000 or more and less than $200 000". The Regulation also states that the responsible Chief Executive for a Territory entity may, in writing, exempt the entity from the above requirement for a particular procurement proposal, so long as the benefit of exemption outweighs the benefit of compliance with requirement.

In accordance with the provisions for exemption under Section 10 of the *Government* Procurement Regulation 2007, it is recommended that KPMG be engaged to provide Commercial Advisor services for the Building 3/2 business case. This recommendation is made on the basis that:

- Commercial Advisor input required for development of health infrastructure business cases is a specialist area with a limited pool of providers available. KPMG are one of the leading experts in this field with extensive relevant knowledge in the area of public health infrastructure.

- KPMG's fee proposal will be checked against benchmarked rates available through the Territory's Commercial Advisor Panel and recent market tested procurement for University of Canberra Public Hospital (UCPH) Commercial Advisor to ensure it represents value for money.

- KPMG are familiar with the ACT Government Tier 3 business case requirements as required under the Single Assessment Framework (SAF) as they previously completed a successful Tier 3 business case for UCPH within the last nine months.

completed a successful Tier 3 business case for UCPH within the last nine months.

- Cabinet requirement to complete B3/2 business case by ~~March~~ Feb 2015, with submission to Chief Minister, Treasury and Economic Development Directorate prior, prevents public tenders being called due to the time required to complete this substantial business case commission.

A funding requirement of $140,000 (excl GST) has been identified. KPMG have identified additional fees for market sounding ($10,000 ex GST) and financial analysis of either a Public Private Partnership or Design, Construct, Maintain, Operate delivery models ($25,000 ex GST) if these are required. Funding has been identified from Clinical Services Inpatient Unit Design & Infrastructure Expansion, cost centre 21327.

A full tender evaluation process will occur in early January 2015 in conjunction with Chief Minister, Treasury and Economic Development Directorate to confirm the initial assessment of the KPMG RFP. This will be advised to the Acting Director-General ACT Health, and if any change in approach is indicated, further approvals will be sought.

Recommendations

That you:

- Note the above information.

(NOTED)/PLEASE DISCUSS

- Approve exemption from requirements of Section six of the Government Procurement Regulation 2007 for the engagement of KPMG Ltd to complete Building 3/2 business case.

(AGREED)/NOT AGREED/ PLEASE DISCUSS

.....

Dr Peggy Brown MBBS (Hons) FRANZCP
Director-General
23 December 2014

Colm Mooney
Director
Procurement and Capital Works, Health Infrastructure
December 2014

Action Officer: Dylan Blom
Extension: 48021

KPMG

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DX: 1056 Sydney
www.kpmg.com.au

Justin Barrett
Project Director
Health Infrastructure Program
ACT Health Directorate
GPO Box 825
Canberra ACT 2601

Our ref 40176969_1

22 December 2014

Dear Justin

Business Case for Phase 1 of the Redevelopment of Canberra Hospital (Buildings 3 and 2)

Thank you for the opportunity to submit a proposal to assist ACT Health with the development of the Business Case for the Redevelopment of Building 3 of the Canberra Hospital (the Project). The purpose of this letter is to set out our methodology, proposed team, relevant experience, and fee proposal to undertake the engagement.

As you are aware we recently assisted ACT Health with the procurement options analysis and Business Case for the University of Canberra Public Hospital. This role, together with KPMG's detailed knowledge of the health sector and experience with developing business cases for major government projects provides us with an excellent insight into the kind of financial, economic and service delivery issues that may arise on a project of this nature.

Background and our approach

The redevelopment of Canberra Hospital will ensure that the high standard of health and healthcare currently experienced in the ACT continues into the future as demand for health care services continues to grow. We understand that a major component of the Canberra Hospital campus redevelopment will involve development of new clinical services buildings replacing the existing buildings known as Buildings 2 and 3 which form the heart of the hospital and will include the Emergency Department, ICU, Operating Theatres, acute care facilities, inpatient and outpatient facilities and ambulatory care facilities. This Business Case is focussed on Phase 1 [redacted] and involves the demolition of Building 3 and construction of a podium and tower for a new clinical services building.

This section summarises the key activities that we will be involved in as part of our engagement to deliver the Business Case and indicative timing for undertaking the tasks.

Activity/ Business Case section	KPMG key activities and tasks	Timing
Project initiation and management	• Initial meeting with the Project Team to confirm our understanding of your requirements, available resources and working arrangements	Week 1
	• Preparation of a draft Table of Contents for the business case including information requirements, allocation of responsibilities and timeframes	Week 1
	• Liaison with ACT Health and project advisors to obtain necessary inputs to the business case	Ongoing
	• Take part in project briefings, meetings and interactive sessions	
	• Regular reporting on progress with the business case	
Project Outline, Needs Analysis and Options Analysis	• Review of Project Brief, Early Project Overview, Clinical Services Plan and other technical studies completed to date	Week 1
	• Prepare description of the project defining outputs and services	Week 2
	• Critically review the Investment Logic Map, available service planning information and discussions with ACT Health to develop the project needs that are being addressed, the project objectives and the project benefits and beneficiaries	Week 3
	• Identify and describe the asset and service options that are to be evaluated in the business case, including an appropriate base case	Week 3
	• Critically review available analysis concerning the staging of the project and prepare a high level strategic assessment of project staging	Week 3
Financial and economic analysis	• Develop recurrent costs for the redeveloped facilities and for a project base case and based on ACT Health advice of forecast separations and applicable benchmark cost rates	Weeks 2 - 5
	• Liaise with the QS to update capital cost estimates, as necessary	Weeks 2 - 5
	• Document all cost assumptions, including the sources responsible for those assumptions, in an Assumptions Book (appendix to Business Case) for sign-off by the relevant Health (and other) managers.	Week 6

Activity/ Business Case section	KPMG key activities and tasks	Timing
	• Conduct workshops to update the project risk analysis and to quantify project risks for inclusion in project budget	Weeks 4 - 5
	• Develop a cash flow model, based on whole-of-life costings, that will generate project capital and recurrent costs for affordability analysis and determination of budget impacts and funding requirements	Weeks 2 - 5
	• Prepare an economic appraisal in accordance with relevant government guidelines to assess the economic justification of the project relative to the Base Case. The appraisal will adopt a Cost Effectiveness Analysis methodology.	Week 6
Delivery model analysis	• Facilitate a workshop with the project team and key stakeholders to assess the suitability of delivery options to the project	Week 3
	• Conduct a market sounding with up to 4 major contractors	Week 4
	• Document the delivery model analysis and recommend a shortlisted option or options.	Week 6
Implementation arrangements	• Describe the proposed governance and project management arrangements and project schedule	Weeks 6 - 7
	• Describe the capabilities and resourcing requirements that will be necessary to manage the procurement process	
	• Describe the stakeholder engagement plan and identify key issues that will need to be managed carefully as the project develops	
Report compilation and finalisation	• Prepare and submit draft Business Case	Week 7
	• Incorporate feedback and submit final Business Case	

Our Team

Our proposed team for this engagement is as follows:

- **Shane Mac Sweeney**, Partner, will be ultimately responsible for KPMG's deliverables and will perform quality reviews on our work. Shane's experience includes business case development, project implementation and leadership, feasibility assessment, commercial

structuring, financial analysis, project management, tender evaluation, pre-qualification analysis and evaluation, payment mechanism structuring, contractual drafting and review of commercial aspects associated with major and complex projects and negotiations. His experience includes:

- Healthscope bid for Northern Beaches Hospital
- Regional Rail Link Project
- High Speed Rail
- Cross River Rail Project
- Railway Procurement Agency (Metro North PPP, Ireland)
- National Development Finance Agency (Metro West PPP, Ireland)
- Irish National Roads Authority PPP Programme
- MRT (Jakarta).

- **Tony Miller**, Director, will be the Engagement Director and will have day-to-day responsibility for preparing the business case and ensuring that all deliverables are provided to the required standard and timetable. Tony will be the key point of contact for ACT Health for the duration of the engagement. Tony brings a significant depth of experience to the Project including:
  - University of Canberra Public Hospital procurement options analysis and Business Case
  - Gold Coast University Hospital Business Case
  - Queensland Health Outsourcing Business Case for Sunshine Coast University Hospital
  - Various business cases and studies for NSW Health (DNA Testing Services, Cardiac Catheter Laboratory, review of Long Bay Prison Hospital budgets, NSW Health Capital Program Review)
  - Healthscope bid for Northern Beaches Hospital
  - Orange and Bathurst Hospitals PPP
  - Newcastle Mater Hospital Redevelopment PPP
- **Alison Knapp**, Associate Director, will work closely with Tony to draft key sections of the Business Case. Alison's relevant experience includes Gold Coast University Hospital Business Case, NSW Health DNA Services Business Case, National Broadband Network – Fibre to the Node project and Sydney Water's South West Growth Strategy.
- **Morgan Pettini,** Analyst, will assist with developing the financial model and support Tony and Alison in drafting key sections of the Business Case. Morgan's recent experience includes the Northern Beaches Hospital, ACT Courts PPP and Westconnex business case.

We have attached CVs for our team members in Appendix A to this letter.

Our Experience

We recognise that high profile government engagements such as this project require advisers who are responsive to stakeholder concerns and have a deep understanding of government requirements and decision-making processes. A selection of relevant major projects where we have demonstrated this and our ability to work in close partnership with our clients to develop practical solutions include:

- **University of Canberra Public Hospital**: KPMG advised ACT Health, Procurement and Works and Treasury directorates on procurement options and business case for a proposed 200 bed sub-acute rehabilitation hospital to be built on the campus of the University of Canberra. The study considered conventional and privately financed delivery methods and included a market sounding process.
- **Sunshine Coast University Hospital and Queensland Children's Hospital**: KPMG prepared a business case to review options for the outsourcing of clinical and support services at each of these major tertiary acute hospitals. The Queensland Government decided to proceed with the full outsourcing of the Sunshine Coast University Hospital and the partial outsourcing of the Queensland Children's Hospital. In each case, KPMG was engaged to provide commercial and financial advice for the procurement of outsourced services.
- **Gold Coast University Hospital**. KPMG prepared the business case for this 750-bed tertiary teaching hospital that opened in 2012 at a capital cost of around $1.5 billion. This role included the development of the project definition, commercial principles, affordability analysis, procurement analysis, financial model (whole of life risk adjusted) and risk assessment and quantification.
- **Sydney International Convention Exhibition and Entertainment Centre:** KPMG prepared the business case and procurement study for Infrastructure NSW and the Sydney Harbour Foreshore Authority for this $1.3 billion project. The role included preliminary and final business cases, development of procurement strategy, market sounding, and preparation of EOI and review of responses. The project has since been procured as a PPP, with KPMG acting as commercial and financial adviser.
- **Moorebank Intermodal Terminal:** KPMG prepared the business case for the Commonwealth Department of Finance and Deregulation for this for the $1.3 billion development of a Defence site at Moorebank as a major new intermodal terminal. The terminal will transfer containers between road and rail and will service Port Botany and interstate freight markets. As Lead Adviser for the project, KPMG coordinated the input of a range of specialist sub-contractors dealing with market demand analysis, freight logistics planning, engineering advice on terminal construction and operations and environmental studies as well as liaising with legal and communications advisers.
- **National Broadband Network**: The NBN is a $43bn complex Commonwealth project with an objective of connecting 90% of Australian premises with fibre-to-the-premises technology offering speeds of up to 100 Mbps. KPMG developed an Implementation Study report for the NBN providing comprehensive analysis and advice on the key aspects of the NBN including

commercial structuring, funding and privatisation, developing a new industry regulatory framework to achieve a market structure which addresses existing competition issues and assessing the role of existing network and utility assets.

Detailed case studies for these and other relevant projects are included in Appendix B.

Our Fee Proposal

[redacted]

[redacted]

Terms and conditions

The engagement will in conducted in accordance with the ACT Commercial Infrastructure Advisers Panel, Contract No. 2012.20254.600.

Conclusion

We hope that you find our proposal compelling and we look forward to talking to you and your team about how we can contribute to the success of the project. If you have any questions regarding our proposal please do not hesitate to contact either Shane [redacted] or Tony [redacted]

Yours sincerely

[redacted]

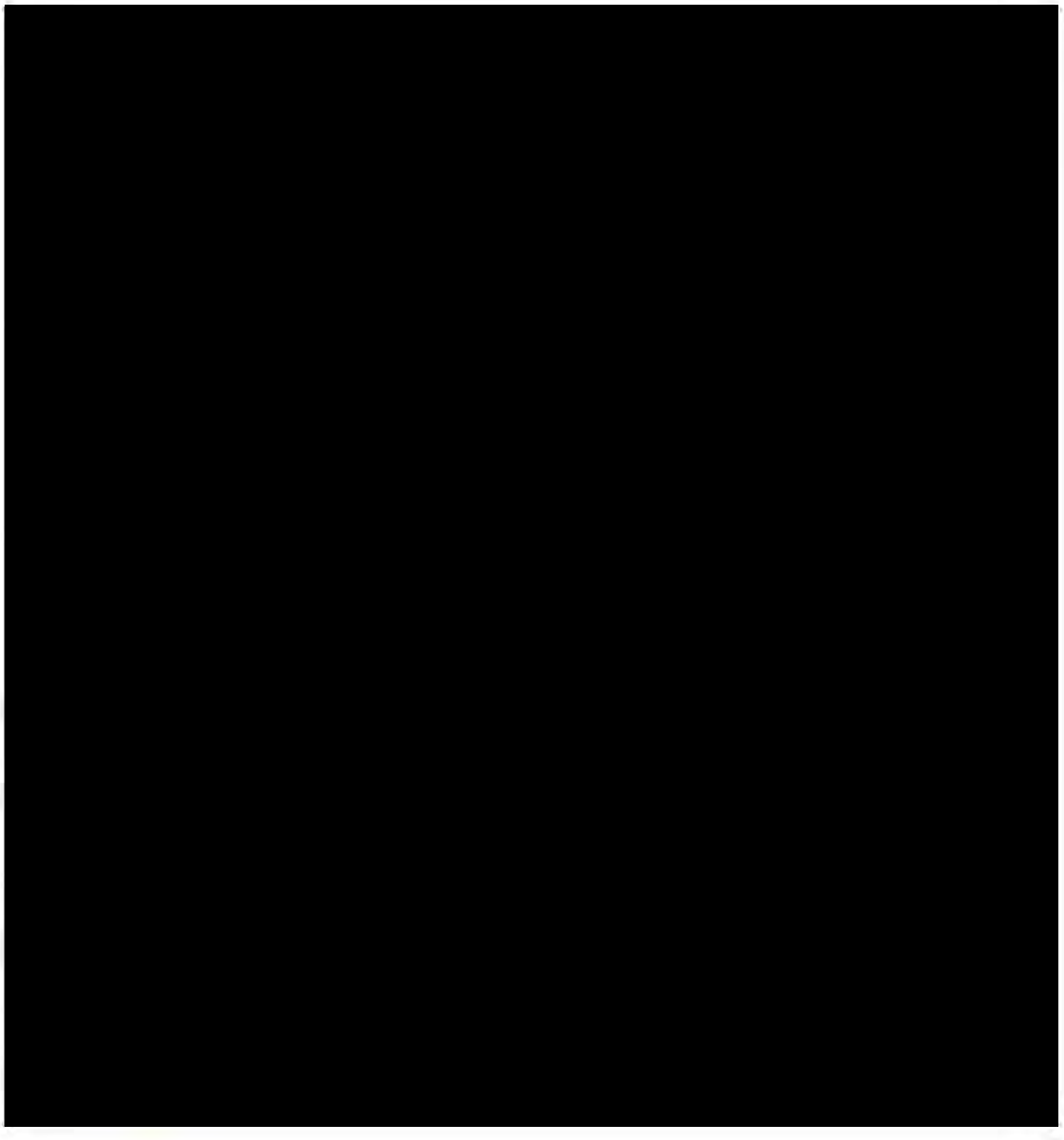
Shane MacSweeney
Partner

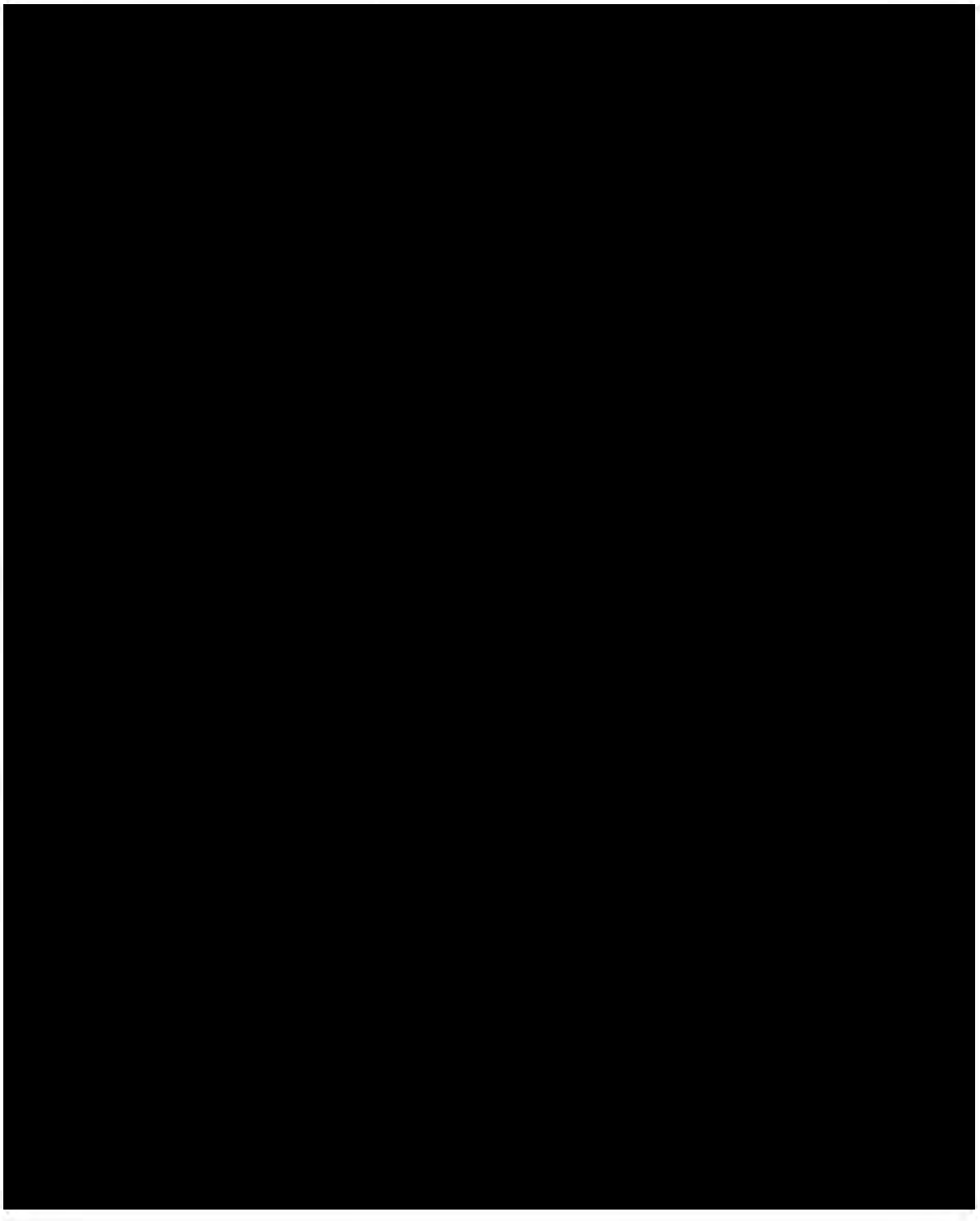
[redacted]

Tony Miller
Director

Appendix A: Curricula vitae

[redacted]





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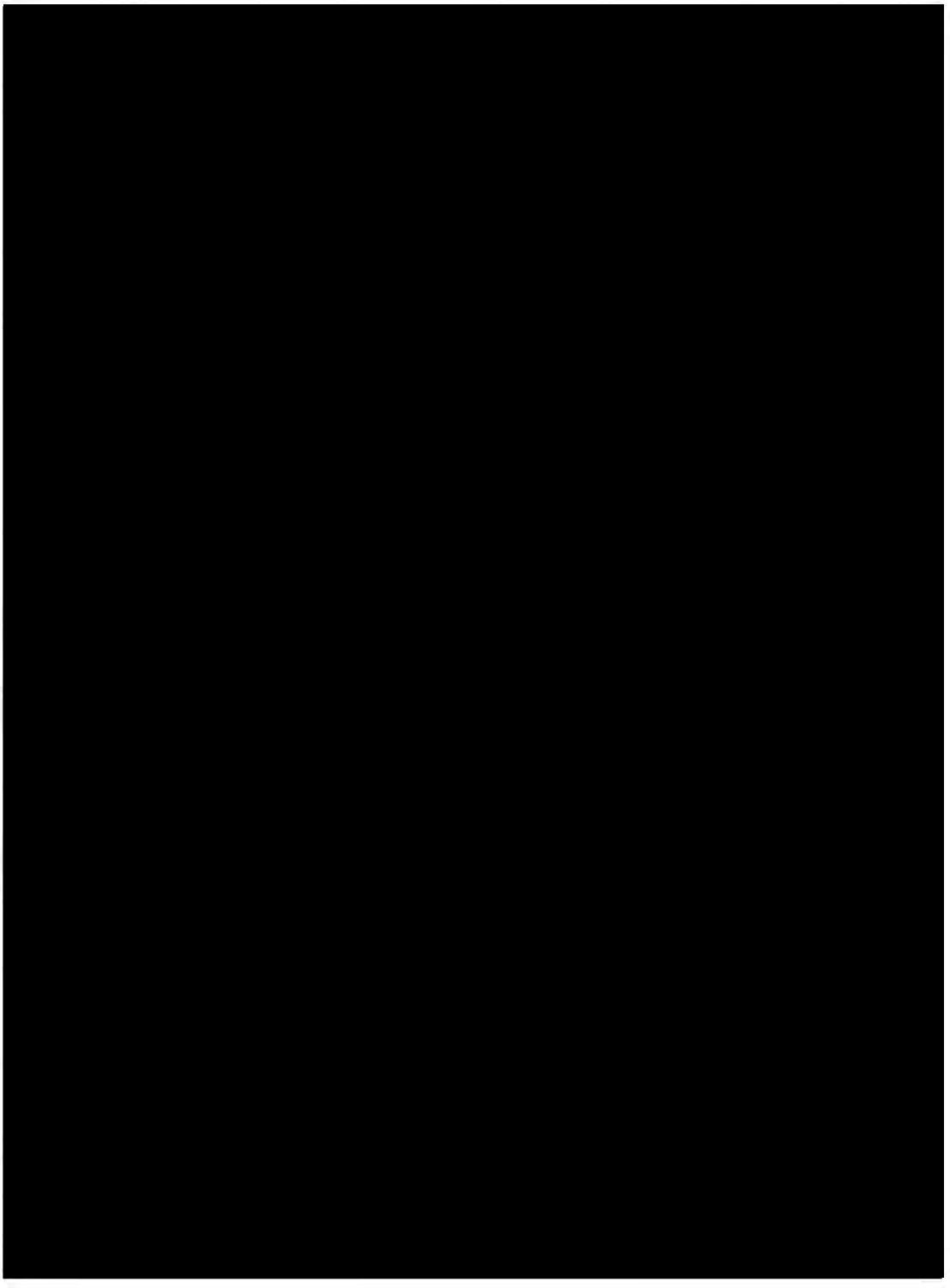

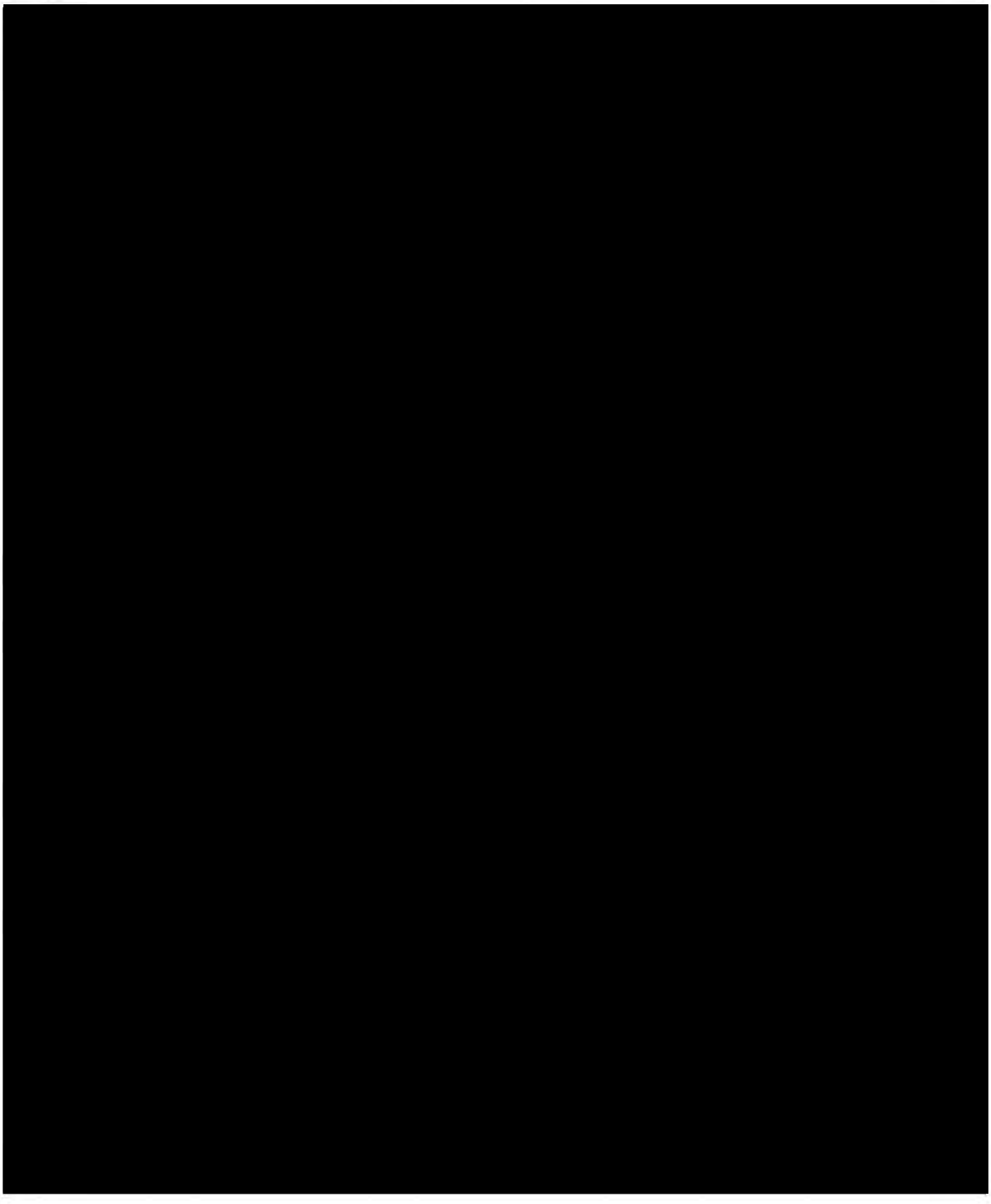

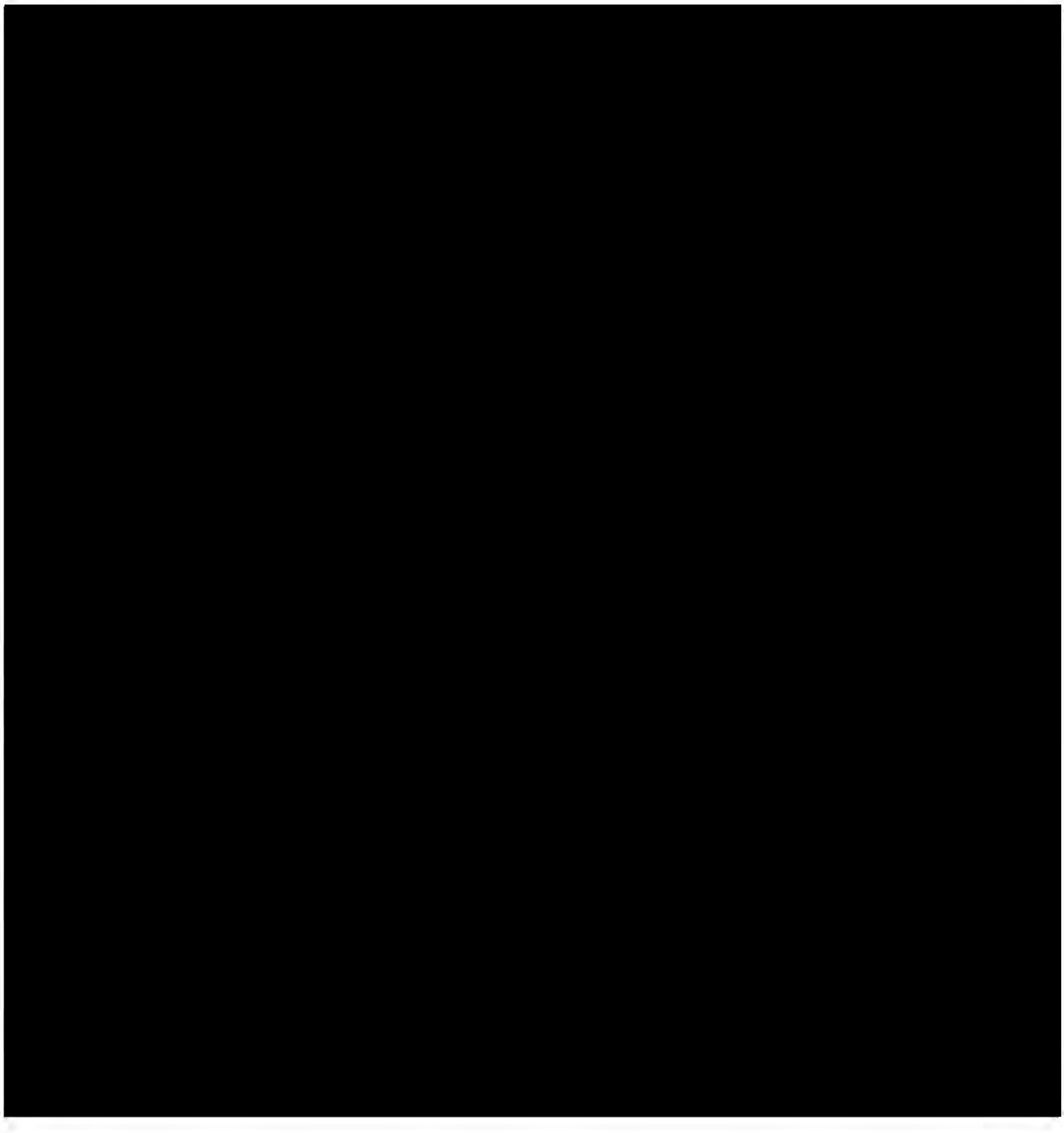

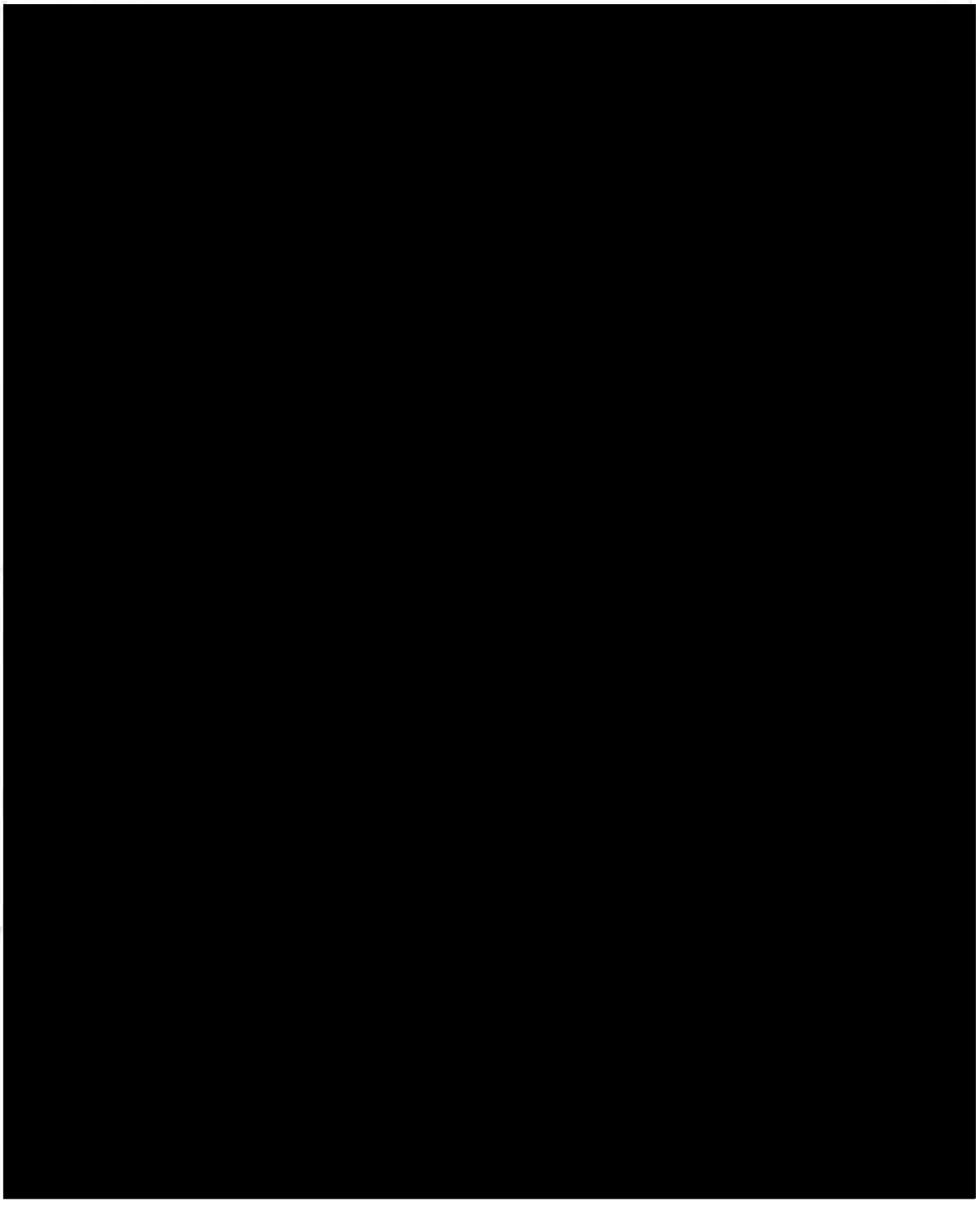

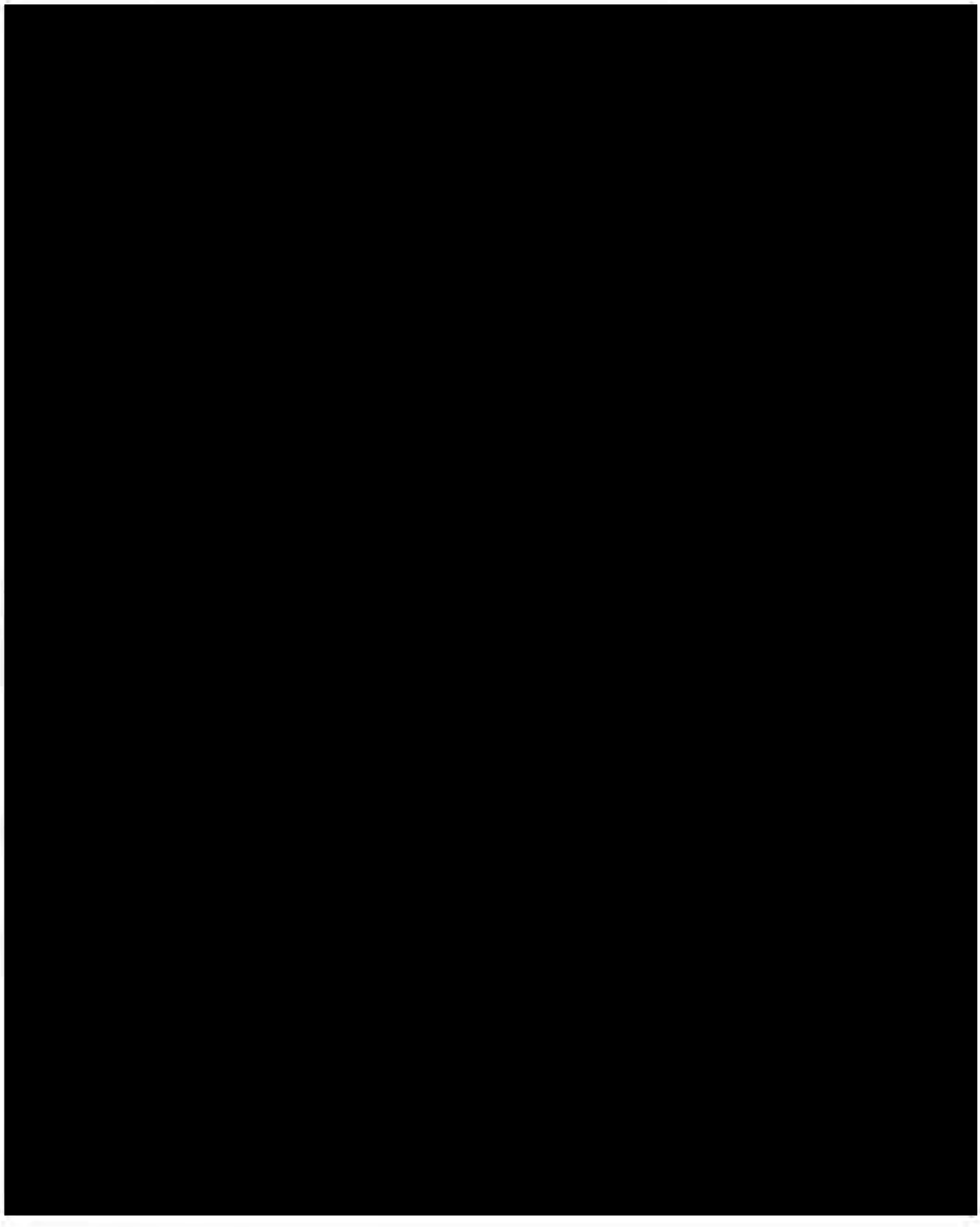

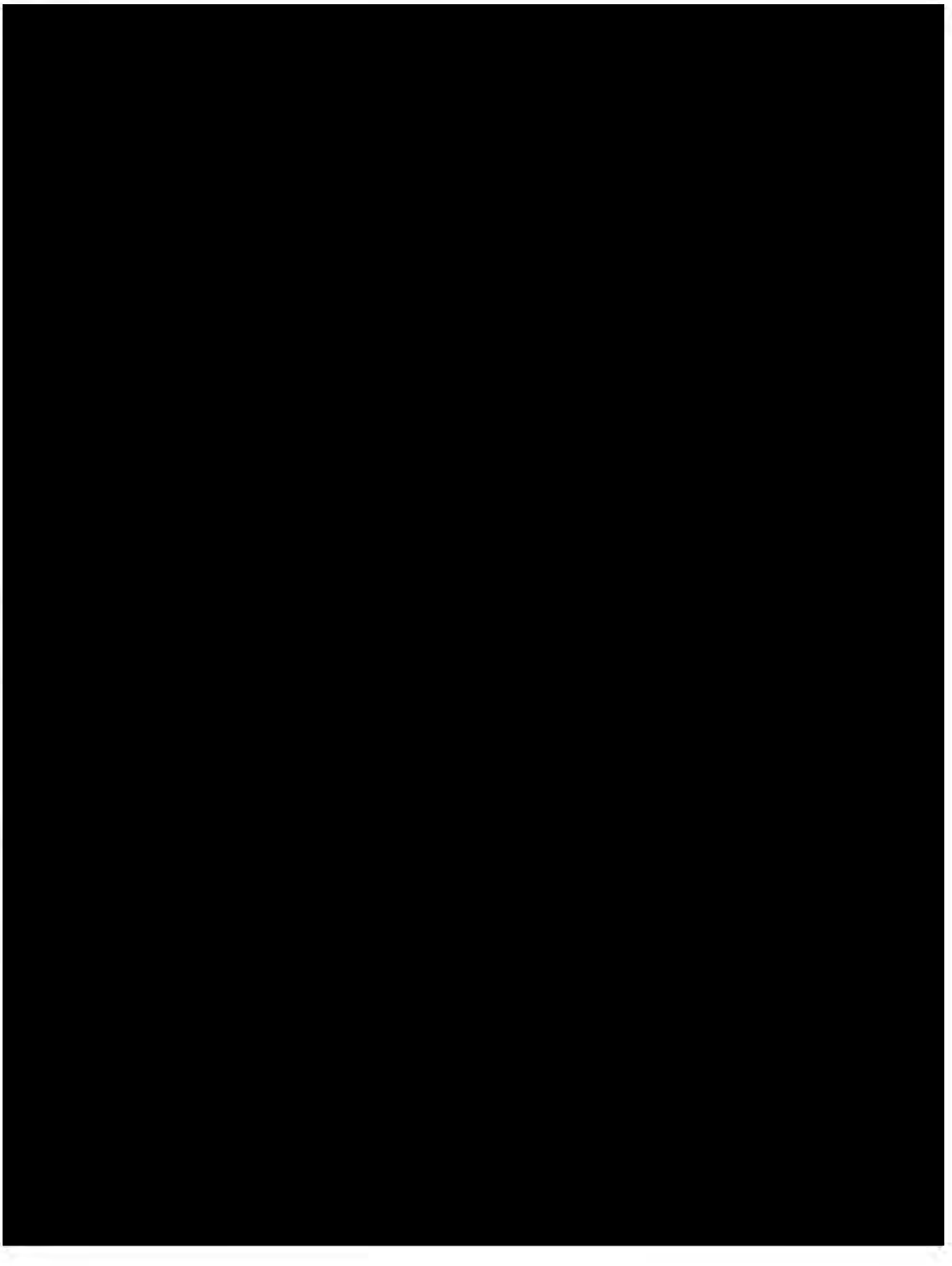

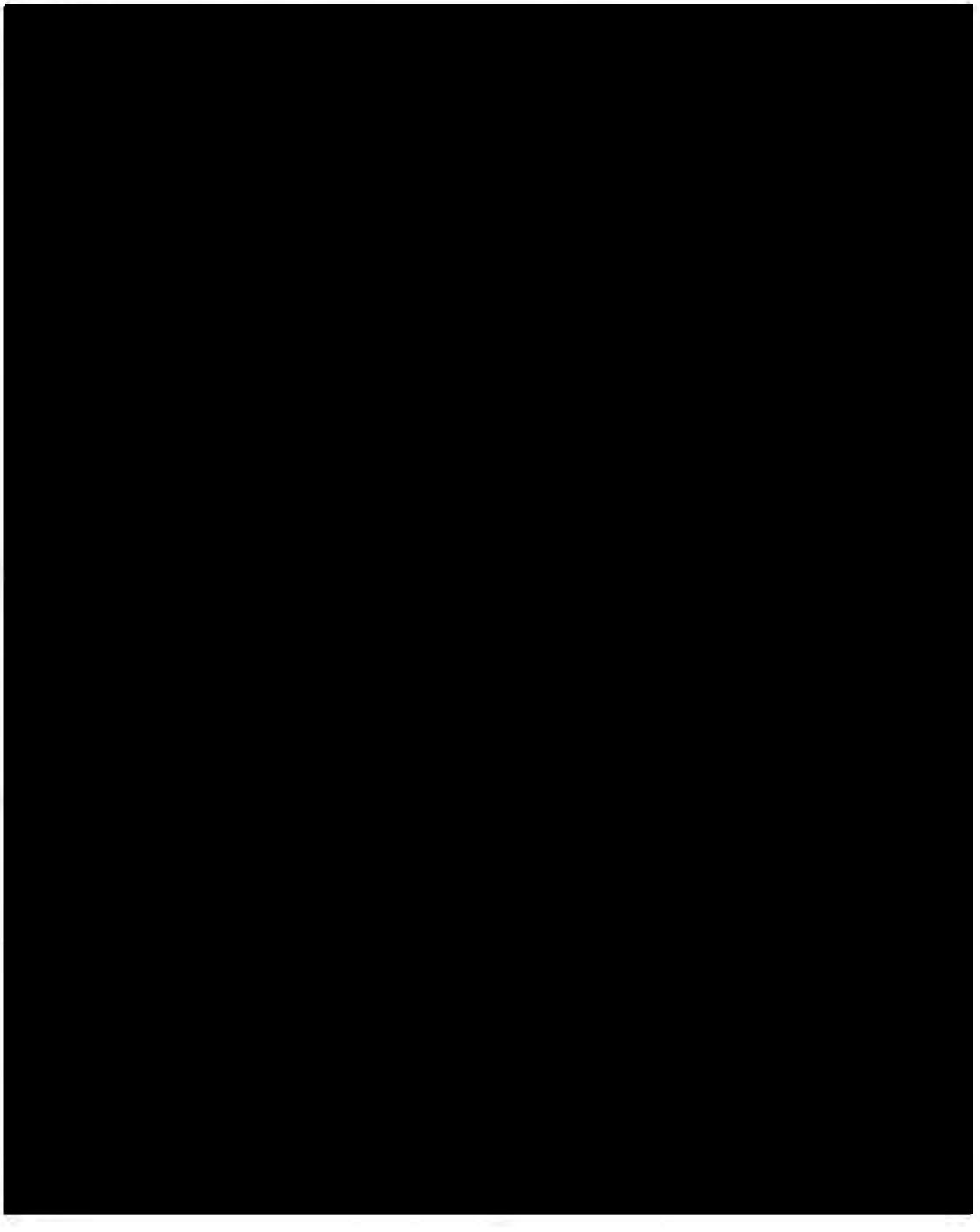

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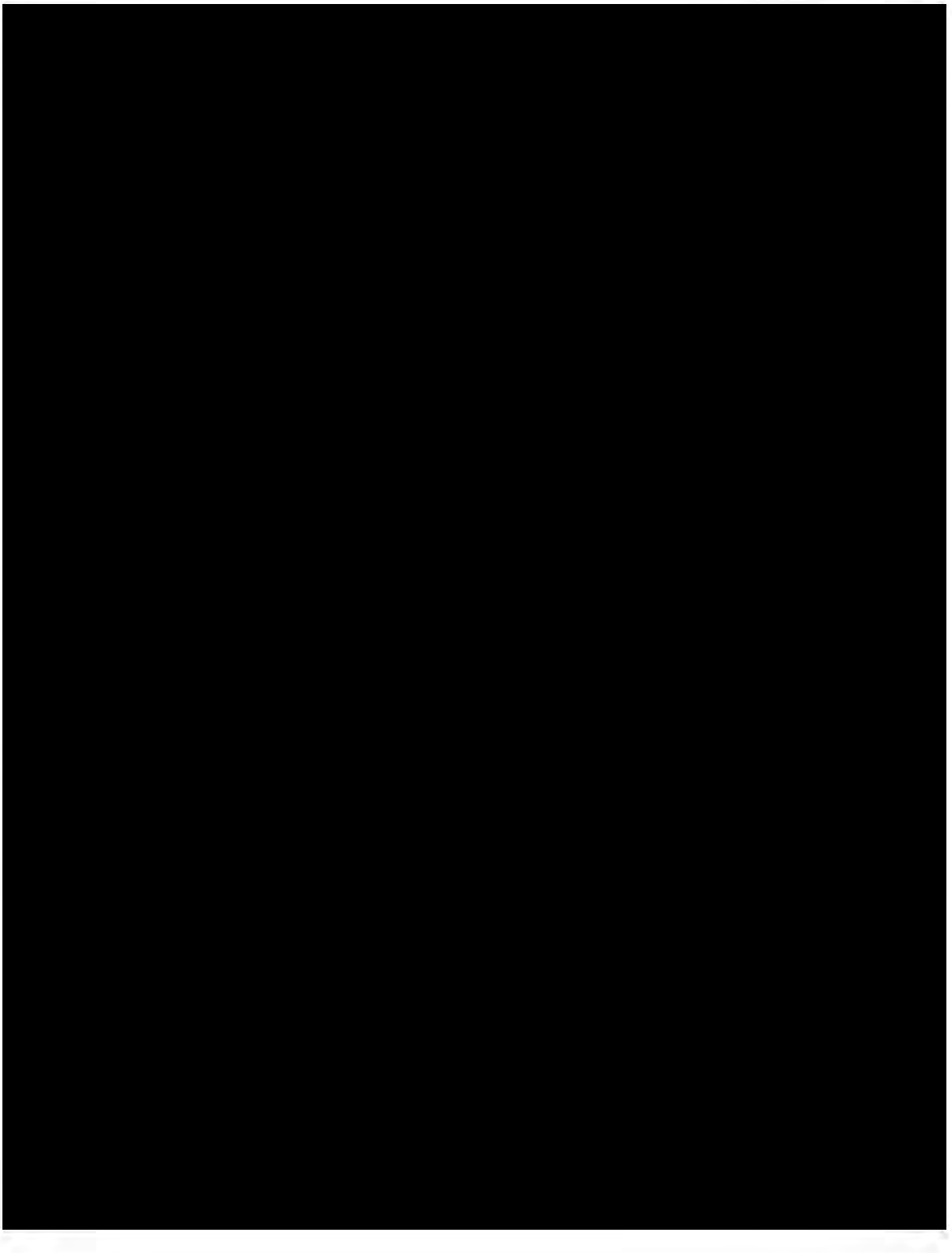

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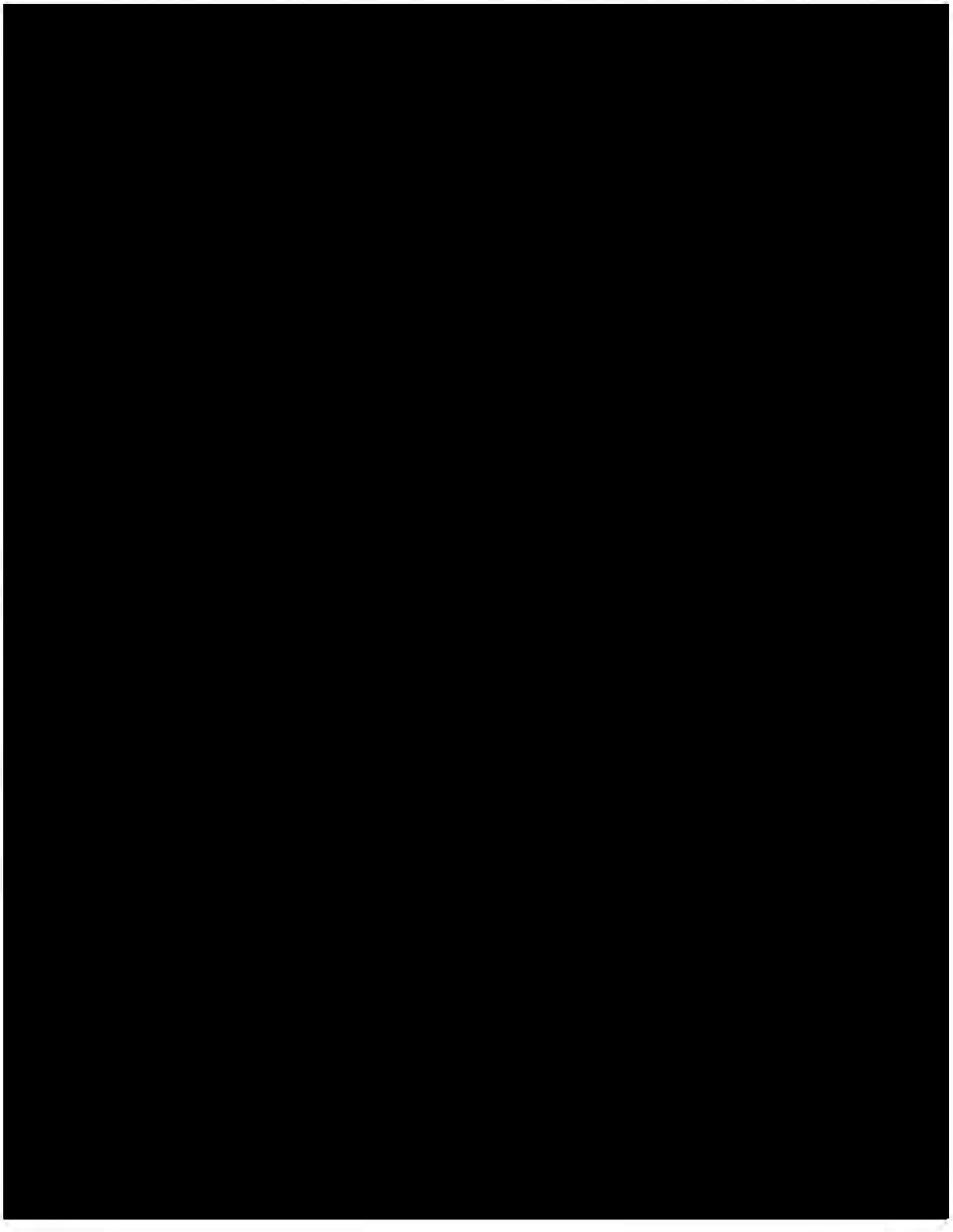

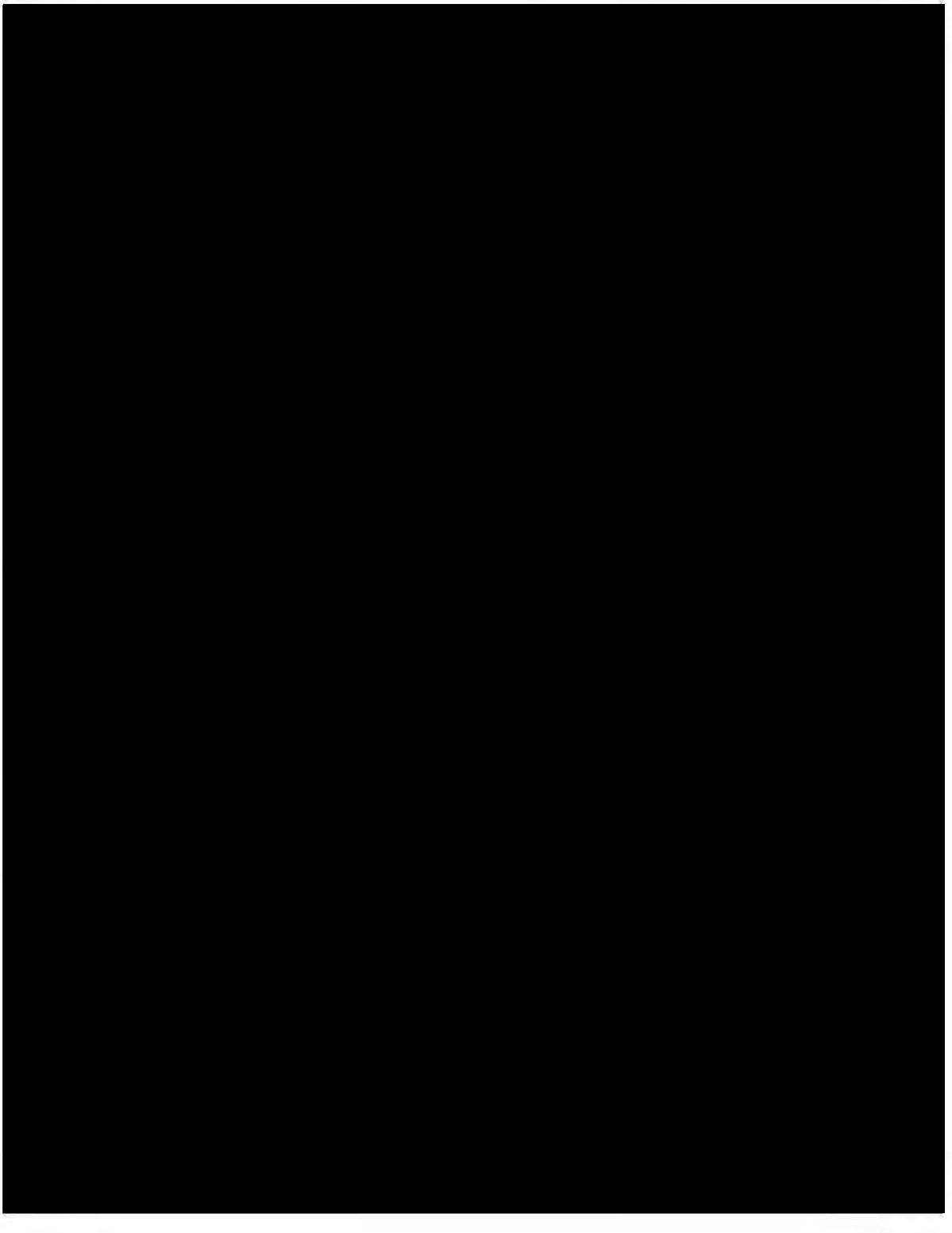

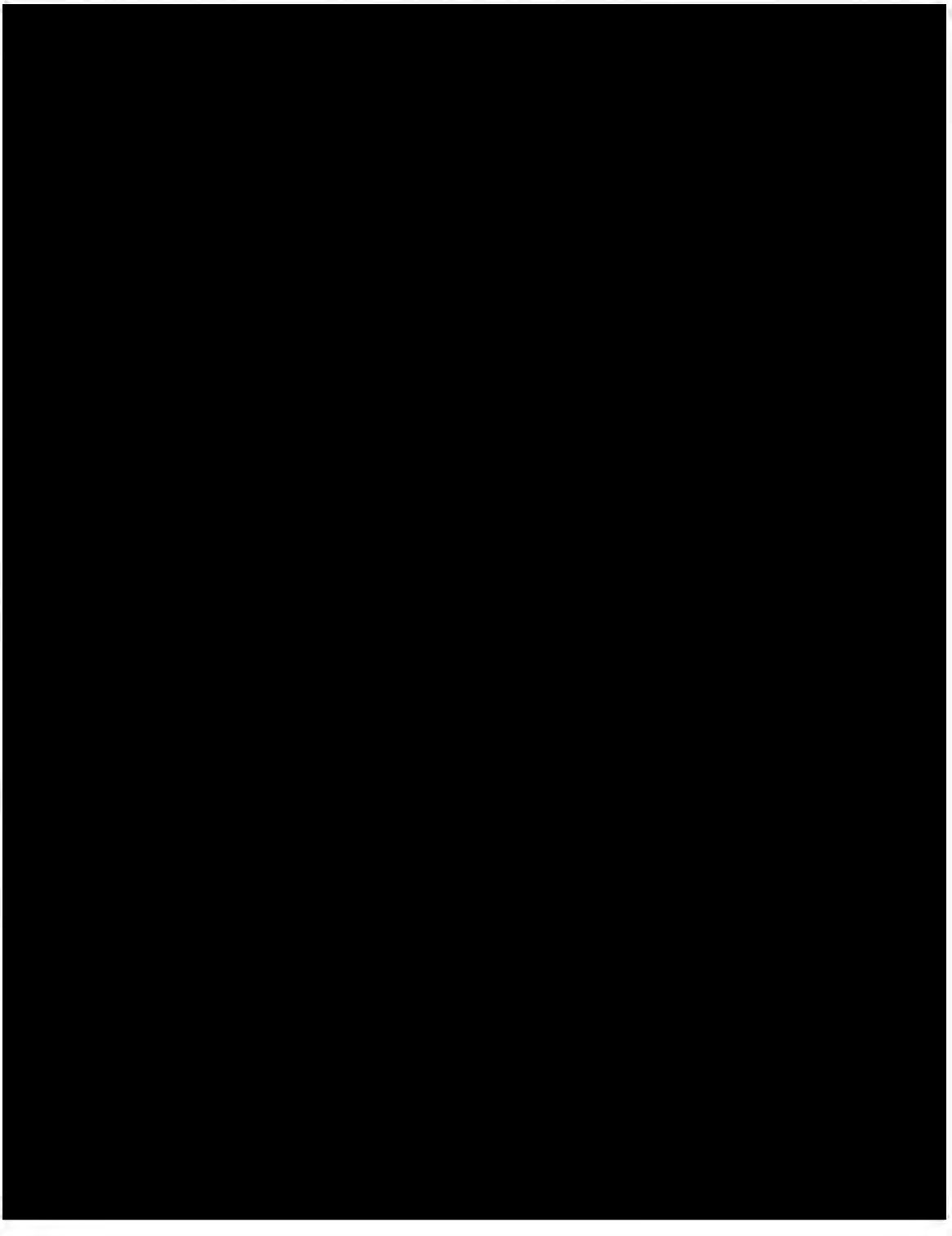

Proposal Hourly Rates Evaluation - KPMG 3/2 Buisness Case

ATTACHMENT C

	KPMG 3/2 Proposal	Infrastructure Commercial Advisory Panel Members									
		KPMG		Price Waterhouse Cooper		Ernst & Young		Aurecon			
Partner	$	$	-$	$	$	$	$	$	-$		
Director	$	$	-$	$	$	$	$	$	-$		
Assoc. Dir.	$	$	-$	$	$	$	$	$	-$		
Analyst	$					$	$				

ACT Government
Health

MINUTE

SUBJECT: Tender Evaluation Report for Commercial Advisory Services and the delivery of a Business Case for the Building 2 and 3 Redevelopment Project

To: Dr Peggy Brown, Director-General, ACT Health

Through: Paul Carmody, Deputy Director-General, Health Infrastructure and Planning [redacted] Submitted 29/1/15

From: Colm Mooney, Director, Procurement and Capital Works, Health Infrastructure

Date: 23 January 2015

Purpose

To seek your approval on the Tender Evaluation Report (Attachment A) to engage KPMG to provide Commercial Advisory Services and the delivery of a Business Case for the Building 3 and 2 (B3/2) redevelopment project.

Background

On 23 December 2014, you approved a minute (DGC14/3047) seeking permission to proceed with the single select procurement of KPMG to act as Commercial Advisor in the development of a Business Case for the B3/2 project.

Within that minute, it was noted that a tender evaluation would occur on the KPMG proposal and that the findings would be presented to the delegate via a formal Tender Evaluation Report.

Issues

An evaluation of KPMG's proposal has been undertaken as detailed in the Tender Evaluation Report at (Attachment A). The report recommends that KPMG be engaged for Commercial Advisor Services and development of the business case for the B3/2 project with an upper limit fee of $175,000.The upper limit provides for a lump sum fee of $140,000, plus market sounding, $10,000, plus financial analysis if required $25,000.

Recommendations

That you:

- Note the above information.

NOTED/PLEASE DISCUSS

- Sign page six and seven of the attached Tender Evaluation Report (Attachment A).

AGREED/NOT AGREED/PLEASE DISCUSS

.....

Dr Peggy Brown MBBS (Hons) FRANZCP
Director-General
3/2/15 *January 2015*

Colm Mooney
Director
Procurement and Capital Works, Health Infrastructure
January 2015

Action Officer: Dylan Blom
Extension: 48021

ACT Government
Health

MINUTE

SUBJECT: Commercial Advisor Services for the completion of Building 3/2 Business Case – Director-General Approval for Confidential Text

To: Dr Peggy Brown, Director-General, ACT Health

Through: Paul Carmody, Deputy Director-General, Health Infrastructure and Planning

From: Colm Mooney, Director, Health Infrastructure, Procurement and Capital Works

Date: 17 February 2015

Purpose

To seek your approval of confidential text in relation to the contract for Commercial Advisor Services for the completion of Building 3/2 Business Case.

Background

A minute and Tender Evaluation Report (TER) for Commercial Advisory Services and the delivery of a Business Case for the Building 2 and 3 Redevelopment Project were approved on 3 February 2015 (DGC15/197).

Issues

As KPMG did not explicitly seek confidential text within their Request for Proposal, the approved TER did not seek approval for confidential text in relation to the Commercial Advisor's (KPMG) contract (Clause 12 of TER).

However, following the TER being approved and the contract being finalised, confidential text was requested.

On Procurement and Capital Works Contracts team advice, "Director-General Approval for Confidential Text" has been attached for approval.

Recommendations

That you:

- Note the above information.

NOTED/PLEASE DISCUSS

- Approve and sign the attached (Attachment A) page eight of eight of the TER (Clause 12 Director-General Approval for Confidential Text).

AGREED/NOT AGREED/PLEASE DISCUSS

.....

Dr Peggy Brown MBBS (Hons) FRANZCP
Director-General
20 February 2015

Colm Mooney
Director, Health Infrastructure
Procurement and Capital Works

February 2015

Action Officer: Dylan Blom
Extension: 48021

12. Director General Approval For Confidential Text

As part of the Tender process, TET has requested under section ***34(1)(a)& (b)*** (***use as applicable***) of the *Government Procurement Act 2001* (GPA) that selected contents of KPMG tender including ***hourly, daily and monthly rates*** to be kept confidential.

In accordance with section 35(1) of the GPA, the responsible Territory entity must not agree to any part of the contract being confidential text, unless satisfied that –

(a) the disclosure of the text would –

- ***(i) be an unreasonable disclosure of personal information about a person; or***
- *(ii) disclose a trade secret; or*
- *(iii) disclose information (other than a trade secret) having a commercial value that would be, or could reasonably be expected to be, destroyed or diminished if the information were disclosed; or*
- *(iv) be an unreasonable disclosure of information about the business affairs of a person;*
- *(v) disclose information that may put public safety or the security of the Territory at risk; or*
- *(vi) disclose information prescribed by regulation for this section; or*

(b) a requirement imposed under law requires a party to the contract to keep the text confidential

(refer highlighted in red) then the Confidentiality request may be granted.

Shared Services Procurement is satisfied that the exemption is allowable in accordance with the provisions of the legislation. Therefore, it is recommended that you agree to the request from the TET to omit from the public text of the proposed contract the ***hourly, daily and monthly rates*** as contained in their tender response, and treat this as confidential text in accordance with section 35 of the GPA.

* NOTE: The confidential text version of the contract will include all information pertaining to the Agreement.

Signature: _____ Date: 20/2/15

Name: Dr Peggy Brown Position: Director-General Health Directorate

ACT Government
Chief Minister, Treasury and Economic Development

Procurement Plan (Variations)

VARIATION OVERVIEW			
To	Director-General/Delegate		
Purpose	This minute seeks your agreement to vary the contract for KPMG to finalise the business case in response to ACT Health and Treasury comments.		
Name of Contract	Business Case for Phase 1 of the Redevelopment of Canberra Hospital (Building's 2 & 3)		
Contract Number	2015.23130.150	**Type of variation**	New contract price
Estimated value of the variation ($)	The original value of the contract was $192,500.00 (including GST). The estimated value of this variation is $44,000.00 (including GST). The estimated total value of this procurement over the proposed period of the contract, including funds already spent and funds expected to be spent under this variation, will be $236,500.00 (including GST).		
Anticipated Commencement Date	Immediately		
Program / contract term implications	No change to contract completion date		
Variation to scope of project / contract	The variation does not include additional scope. It relates to additional hours required to finalise the business case in response to ACT Health and Treasury comments, as well as, an allowance for ongoing responses and rework as required by ACT Health.		
Is Government Procurement Board (GPB) sign off required?	No		

ORIGINAL PROJECT	
Background	On 23 December 2014 a Minute (COR14/15437) was approved by ACT Health Director-General to proceed with the single select procurement of KPMG to act as Commercial Advisor in the development of a Business Case for the B3/2 Project. Following this a value for money assessment was conducted on KPMG's proposal to ensure it represented value for money for the Territory. On 3 February 2015 a Tender Evaluation Report was approved by ACT Health Director-General (COR15/779).
Provision for variation	Clause 12.7

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Key Performance Indicators under the contract	The consultant has performed well given the short time frame. They have produced professional services to meet the requirements of ACT Health.
Social Procurement	NA

PERFORMANCE AND RISK	
Risk	Refer to Attachment A – Risk Plan

EXEMPTIONS	
Exemption	Yes - Exemptions may be granted from the requirements of section 6 or 9 of the *Government Procurement Regulation 2007*. *Government Procurement Regulation 2007* Section 10 (1) specifies that "The responsible director general for a territory entity may, in writing, exempt the entity from..." the quotation and tender thresholds outlined in section 6 or section 9 for a particular procurement proposal. Section 10 (2) specifies that "...the responsible director general may exempt the entity only if satisfied, on reasonable grounds, that the benefit of the exemption outweighs the benefit of compliance with the requirement" and provides examples of when an exemption may be given. An exemption made under Section 10 does not remove the requirement to undertake a value for money assessment. A procurement that is undertaken utilising a single select process must still ensure that a value for money assessment is undertaken through the action of seeking a response to approved assessment criteria and evaluation against those criteria with regard to the value for money principles.
Reason for Exemption	The minute approving single select procurement of KPMG approved 23 December 2014 (COR14/15437) outlined the following reasons for single select procurement: • Commercial Advisor input required for development of health infrastructure business cases is a specialist area with a limited pool of providers available. KPMG are one of the leading experts in this field with extensive relevant knowledge in the area of public health Infrastructure. •KPMG's fee proposal has been checked against benchmarked rates available through the Territory's Commercial Advisor Panel and recent market tested procurement for University of Canberra Public Hospital (UCPH) Commercial Advisor ensuring best value for money. •KPMG are familiar with ACT Government Tier 3 business case requirements as required under the Single Assessment Framework (SAF) as

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EXEMPTIONS	
	they previously successfully completed a Tier 3 business case for UCPH. •Cabinet requirement to complete B3/2 business case by March 2015 prevents public tenders being called due to the expected timeframe to complete this substantial business case commission.

PROCUREMENT AND CAPITAL WORKS RECOMMENDATION			
Project Officer	Peter Stringfellow	Phone Number	6174 7293
Signature	[redacted]	Date	16/4/15
Manager	SOPHIE GRAY	Phone Number	61747022
Signature	[redacted]	Date	16.4.15

AGENCY ENDORSEMENT			
Name		Phone Number	
Position, Branch & Section			
Signature		Date	

DIRECTOR-GENERAL/DELEGATE APPROVAL			
Name	Dr Peggy Brown		
Position	Director-General/Delegate		
Statement	Funding for this Variation Plan and attachments are approved. I am satisfied that the benefit in giving the exemption outweighs the benefit in requiring compliance with the quotation and threshold requirements set out in the *Government Procurement Regulation 2007*. I am satisfied that a value for money assessment has been undertaken against approved assessment criteria with regard to the value for money principles.		
Signature		Date	

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Attachment A

Procurement Risk Management Plan

Project Details	
Project	Commercial Advisory Services and the delivery of a Business Case for the Building 2 and 3 Redevelopment Project.
Project Objectives	The objective is to procure Commercial Advisory Services for the development of the Building 2 and 3 Redevelopment Project Business Case

Contact Details:				
Directorate	CMTEDD	**Business Unit** *(If applicable)*	PCW HIP	
Name of Contact	Peter Stringfellow		**Phone no.**	X47293
Name of Decision Maker / Authority Holder				

Created by: Peter Stringfellow **Date:** 27/03/2015 **Reviewed by:** Margaret Mialkowska **Date:** 30/03/2015

Stakeholder Analysis		
Internal and External [Name and Agency/Organisation]	**Level of Influence** [Ability to influence project outcomes]	**Level of Interest** [Level of interest in the project outcome]
Minister for Health – ACT Health	Outcomes of the Business Case	Very High
PCW	Responsible for the management of the Commercial Advisors Contract.	Very High
ACT Health	Outcomes of the Business Case	Very high
CMTEDD -Treasury	Outcomes of the Business Case	Very High

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Risk Register

This risk register is consistent with AS/NZS ISO 31000:2009 risk management standard and the CMTEDD Risk Management Framework and Policy Statement; and Risk Management Policy.

Risk Ref. No.	Risk Description (source/ Cause) The risk event, source and cause What can happen (that will affect our ability to meet our objectives) and how it comes about.	Describe the consequence If what can happen does happen what is the impact or outcome? (In its most '**normal**' form – not an extreme form)	Risk controls – what is in place to manage the risk. How are risks to be Managed? What ordinary policies, procedures and actions (BAU) are to be taken to manage the risk?	Risk Owner *(entity who manages the risk)*	Consequence	Likelihood	Current risk rating	Control effectiveness
1	**Unethical Tendering Process** Inadequate tender and evaluation process; breach of probity.	Poor public perception of Government procurement process; and possible legal challenge to tender process.	• Ensure required approvals are in place; • Use of consultant from Commercial Advisors Panel; • Probity Advisor to be consulted *if required.*	PCW	Min	U/L	Low	Adq
2	**Procurement Process does not accord with legislative, policy or operational requirements**	Potential need to restart process; Possible delays in finalising process; and Criticism, complaints, negative media attention.	• Use of an experienced procurement officer as project officer; and • Use of consultant from Commercial Advisors Panel.	PCW	Mod	U/L	Med	Adq
3	**Delays in the Procurement Process**	Delays in contract award and delivery of the Business Case.	• Fast tracking of Preparation of Procurement documentation.	PCW	Mod	U/L	Med	Adq
4	**Consultants fee** The consultant's fee does not represent value for money for the Territory.	Potential need to restart process; delays delivery of the Business Case; and Poor public perception of Government procurement process	• The variation to the original engagement will be in accordance with the original contract conditions including contract rates; • Benchmark against the Commercial Advisors Panel rates to asses if it represents value for money.	PCW	Min	U/L	Low	Adq
5	**Adequacy of consultants budget**	Additional funding is required; Delay to the delivery of the Business Case.	• There is an allowance for the Business Case development for this project. The allowance has been determined by that required for the UCPH Business case.	PCW	Min	Poss	Med	Adq

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Risk Treatment Action Plan

A risk treatment action plan is required for all risks rated as **"Extreme"** or where the control effectiveness rating is **"room for improvement"** or **"inadequate."**

Risk Ref. No.	Risk Description (source/ Cause) *The risk event, source and cause. (Copied from above)* *What can happen (that will affect our ability to meet our objectives) and how it comes about.*	Additional Risk Treatments or actions to be taken: to Manage the risk. *(In addition to the Business as Usual Controls listed above.)* *Could include a different treatment action for a new procurement (new technology) or an unusual project with different installation or construction techniques. For example: may include additional processes and procedures for sites that are known to contain asbestos.*	Consequence	Likelihood	Residual Risk Rating	Control effectiveness	Implementation and Reviewing		Emergency Response Should Control Measures Fail. *(The risk is realised.)* *Contingency Plan.*
							Responsible Officer *(Officer responsible for implementation and ongoing review.)*	Implementation Date *(Date to be completed by)*	
Nil			**	**	**	**			
			**	**	**	**			

ACT Government
Health

MINISTERIAL BRIEF

GPO Box 825 Canberra ACT 2601 | phone: 13 22 81
www.health.act.gov.au

UNCLASSIFIED

TRIM No.: MIN15/277
Date Rec'd Minister's Office .../.../...

To: Minister for Health

From: Dr Peggy Brown, Director-General ACT Health

Subject: Canberra Hospital Building 2/3 Redevelopment – Procurement Model Comparison

Critical Date: No critical date

Critical Reason: No critical reasc

Please send back to HIP to address the comments today - return directly back to me please

(PB) 27/2

- DG Health .../.../...
- DDG HIP .../.../...

Purpose

1. To provide you with comparative advantages and disadvantages of two procurement options under consideration for the Canberra Hospital Building 2/3 Redevelopment ('Building 2/3 project').

Background

2. At your meeting with representatives of ACT Health on 16 February 2015 you requested background to two of the procurement options that will be analysed within a business case for the Building 2/3 project for consideration in the 2015-16 Budget.

3. The proposal to redevelop the existing Canberra Hospital Buildings 2 and 3 is driven by the need to deliver increased capacity across the public health services network by 2021- 2022, to address increased health care demand generated by population growth, ageing population, chronic and complex disease.

This probably needs a bit of explanation

4. The original health buildings and infrastructure on Canberra Hospital campus are unable to meet this demand, with the majority dysfunctional and at the end of its design life.

5. A Proof of Concept Study (POC) was completed in September 2014 by specialist health architects – Silver Thomas Hanley (STH) to inform the proposed redevelopment. The POC provides for a flexible staged building design solution that can adapt to changing models of care and allow for future expansion. The proposed design solution also allows for the redevelopment of Buildings 2 and 3 to be delivered within two phases, with multiple stages within each of these phases also possible.

6. Phase One is the demolition of the existing Building 3 and the construction of a new building consisting of a podium and tower building with a total area of some 70,000 m^2.

7. Phase Two is the demolition of the existing Building 2 and the construction of a new building with a podium and tower with a total area of some 40,000m^2. [redacted]

8. [redacted]

9. A decanting and relocation project is currently underway to vacate Building 3. Based on the existing program for the decanting project it is expected that the demolition of Building 3 can commence from mid 2016.

10. The site and the proposed redevelopment solution involves a number of unique issues, given the redevelopment is located at the physical midpoint of the Canberra Hospital campus. To enable the continued pedestrian connectivity between the northern and southern ends of the campus and the main entry to the hospital, admissions functions and associated staff and retail facilities to be maintained during the redevelopment, the project will need to be undertaken in two distinct and separate phases.

Government Commitment – Cabinet Decision

11. In November 2011, Cabinet provided in principle agreement to proceed with a staged implementation of the Health Infrastructure Program (then Capital Asset Development Plan), with each component of the staged implementation to be presented to the Budget Committee of Cabinet in a business case for consideration and decision. The staged implementation included a 'redeveloped Canberra Hospital'.

Issues

12. In early 2015 the consultant company KPMG was commissioned by ACT Health to produce a business case for consideration in the 2015-16 Budget. The Business Case is being prepared in accordance with the requirements of the Capital Framework.

13. As part of this business case preparation a Procurement Options Workshop was held to identify and examine the suitability of a range of procurement options. As a result a shortlist of procurement options were examined, these included:
    - Public Private Partnership (PPP)
    - Early Contract Involvement (ECI) (Two Stage Lump Sum)
    - Design, Construct, Maintain
    - Design and Construct.

14. The identified procurement models were examined and evaluated against a set of eight criteria. The procurement models of PPP and ECI were assessed and ranked the highest against these criteria. An examination of the advantages and disadvantages of these two models are provided below.

<u>Public Private Partnership (PPP)</u>

15. A PPP is a long term service contract between the Territory and the private sector where the Territory pays the private sector (typically a Special Purpose Vehicle or "Project Company") a monthly service fee post completion of the works to deliver infrastructure (hospital buildings) and related hard and soft facilities services over an agreed project term (nominally 20 – 30 Years). In a PPP the Project Company effectively owns and operates the hospital facilities over the term of the concession and staff employed by the Territory are "tenants" within the building.

16. During the concession period the Project Company is required to maintain the facilities to certain standards and to rectify faults within a prescribed time frame. If the Project Company fails to achieve this within the specified standards and timeframes they are "Abated" and charged a fee for non performance.

17. Recent examples of public hospitals being delivered under a PPP within Australia include:
    - Sunshine Coast University Hospital, 738 Bed, $2 billion, four years from financial close to planned completion
    - The New Royal Children's Hospital, 350 Beds, $984 million, four years from financial close to construction completion.

18. In the context of the Canberra Hospital redevelopment the advantages and disadvantages of a PPP can be summarised as follows:

Advantages

- Full integration of design, construction, financing, maintenance, operation and refurbishment and decanting responsibilities.
- High degree of risk transfer to the Project Company from the Territory for design, fit for purpose, cost and program.
- Opportunity to develop innovative capital solutions.
- Capital assets are maintained to a high standard throughout the concession period.
- Less upfront design and scoping work required to be undertaken by the Territory.
- Under the Capital Framework, no delivery model contingency applied.
- Transfer of lifecycle cost risk (replacement of building services equipment at specified intervals by the project company) encourages efficient design, quality construction and finishes.
- Performance standards for the maintenance and operation of the new hospital will be in place and the project company will be financially impacted if these are not met.
- Interactive bid process encourages timely decisions on design of the project.
- A high degree of cost and delivery certainty post financial close.

Disadvantages

- No less expensive than a traditional delivery method to achieve a capital and maintenance solution. In some cases within Australia it has been estimated that the PPP solution for hospital redevelopments will cost significantly more than a traditional delivery method.
- Protracted delivery time to market due to the need to prepare detailed performance based specifications for capital and facilities maintenance solution. An indicative timeframe is 9-12 months.
- A further 9 – 12 months is the typical time period to tender, assess and award a PPP contract. As a result, the typical time period from inception to award is 18 - 24 months.
- Extensive time required by clinical staff for input into the design development phase during the tender period by multiple tenderers through the interactive tender process.
- High tender costs for the Territory. An estimate for a project of this scope could be in the range of $5 - $8 million.

- Detailed design is finalised over a compressed period during a tender phase. As a result the design is "Locked in" at financial close and material changes beyond this point are costly to the Territory.
- Clinical, user and stakeholder inputs are limited to a set number of workshops during the design bid phase.
- No incentive by the Project Company to procure facilities that will achieve clinical operating cost savings. Orange Hospital NSW - PPP is an example where the design impacts negatively on clinical operational costs.
- Territory does not have immediate control of the hospital facilities and acts as a "tenant" within the hospital during the term of the lease.
- Risk of users and stakeholders rejecting building on completion due to disconnected process during design development through the tender process.
- The design and construct tender will have proportionally high inbuilt risk costs to cover for unknown risks on brown field sites, such as those at the Canberra Hospital site.

Early Contractor Involvement - (ECI) Two Stage Lump Sum

19. An ECI two stage lump sum procurement model is a traditional delivery model for the procurement of capital works. The ECI model consists of two distinct stages.

20. Stage One - at the conclusion of a competitive tender process, the Territory appoints a construction contractor to work with stakeholders to progressively prepare a detailed design within a defined budget or Target Construction Sum (TCS).

21. During the development of the detailed design progressive cost plans are provided by the contractor to check the scope of the design against the TCS. As the design progresses the contractor assumes all design risk and as a result undertakes all additional studies and investigations to mitigate these risks.

22. At the conclusion of Stage One the contractor delivers an approved design, a fixed lump sum price (Guaranteed Construction Sum) and a program to deliver the works.

23. Once the Stage One package of deliverables is accepted by the Territory the contractor accepts all scope cost and time risks.

24. In the event that the contractor cannot submit a GCS that is less or equal to the TCS then the Territory has the right to tender the project – using the designs prepared by the contractor – to the open market.

25. Stage Two - involves the construction of the project in accordance with the approved design and the agreed Guaranteed Construction Sum and the contract program.

26. Recent examples of public hospitals being delivered by ECI within Australia include:

- Gold Coast University Hospital, 750 Bed, $1.4 billion, four years from tender close to completion.
- Queensland Children's Hospital, 359 Beds, $1.2 billion, seven years from financial close to construction completion.
- Other major NSW hospitals delivered under ECI include, Westmead Adults, Liverpool Hospital and Wagga Wagga Base Hospital.

27. In the context of the Canberra Hospital redevelopment the advantages and disadvantages of an ECI delivery model is as follows:

Advantages

- Provides a very high level of staff, hospital user and stakeholder input during the detailed design phase within a considered timeframe.
- Staff and end users have more ownership of the design and project and are less likely to reject the end facility when completed.
- Greater degree of control of the design by the Territory which provides the ability to provide clinical operational recurrent cost savings.
- Contractor is able to accept more site risk during the Stage One phase. The contractor has the opportunity to undertake detailed investigations of the site in a considered timeframe during Stage One and can mitigate, accurately cost and accept site risks.
- Low bid cost to industry and to the Territory.
- Detailed design is undertaken only once, as opposed to up to three times in a PPP process.
- High degree of risk transfer to the construction from the Territory for design, fit for purpose, cost and program after Stage One has been completed.
- Opportunity to develop innovative capital solutions within Stage One.
- Time to market is short.
- Timely decisions on the agreement of the design of the project are encouraged as the contractor is at time and cost risk during Stage One.
- A high degree of cost and delivery certainty post acceptance of the Guaranteed Construction Sum.

Disadvantages

- Maintenance and operational cost risk not transferred to the contractor in this model.
- Negotiations to agree GCS may be protracted and could delay project. (Based on NSW Health Infrastructure information this has only occurred once on a major hospital project in the last five years).
- Not as competitive as a "Construct only" or "Design and Construct" model. Under the ECI model the contractors design fees, preliminaries, management fees and profit are all competitively tendered at the commencement of the tender process across a number of tenderers. However the GCS is agreed and locked in at the completion of Stage One with one contractor.
- Under the requirements of the Capital Framework, the ECI delivery model is required to include delivery model contingency into the total cost. This is in addition to any project level contingencies and is held and released as needed by Treasury. Delivery model contingency levels vary, and are set within the Capital Framework.

28. The Infrastructure Finance & Advisory Division (IFAD) of Treasury have advised they view the ECI model as being closer in risk profile to an 'Alliance' delivery model, with a delivery model contingency of 50 per cent. [redacted]

29. ACT Health note a project contingency of 25 per cent is currently budgeted within the cost estimates. Verbal advice from NSW Health Infrastructure based on similar ECI delivery model projects and the current project contingency has suggested that the contingency level indicated by IFAD could be challenged and reduced to reflect contingency for an ECI model as compared to a contingency for an alliance model.

30. As indicated, the proposed redevelopment as described in the POC report realises a number of issues not normally experienced on similar brown field site developments. The issues and possible influence of these on delivery model options are:

- The proposed development bisects and separates the acute hospital facilities on the campus. In effect during construction this separates the hospital into two separate "halves". As a result any procurement model will need to provide physical connectivity between both ends of the campus.

- The proposed redevelopment is located within the middle of the campus and relies and has active interfaces with other clinical and support services within the hospital. As a result the development is not a standalone operational element as is the case on other similar brownfield hospital developments such as the Royal North Shore Hospital in NSW. A PPP procurement model will be affected and maybe compromised by this issue. In addition the definition of "The Site" under an operating deed for a PPP model will be complex to define and problematic to manage.

- Building 3 and Building 2 will be required to be developed in discrete stages on a "Start on Finish" basis to permit continued operation of the front entry of the hospital, front of house operations and the switch over of the main hospital electrical switch room (supplying power to the majority of the campus). As a result of this staging a prolonged procurement process will be required – five plus years. The prolonged procurement period will be problematic for a PPP delivery model.

- Dependant on the final staging of the development, dislocation and separation of a number of acute functions will occur. The operational risk associated with this will be extremely hard to transfer to an operator under a PPP model.

31. In order to allow the Territory flexibility in capital funding and cash flow the redevelopment has been intentionally designed to permit a number of discrete stages within two main phases of works. The design allows the opportunity to undertake small discrete packages of work or combining these stages to undertake one large phase of works. A PPP procurement model is not suited for a progressive staged development occurring over a number of small stages. An ECI procurement model is flexible in accounting for future staged developments.

Financial Implications

32. As outlined in the advantages and disadvantages of both the PPP and ECI, the total project cost and ongoing recurrent costs may be influenced by variables of the delivery models, including the bid cost, delivery model contingency, time to procure and the resulting design influencing capital asset maintenance and clinical operating costs.

Directorate Consultation

33. Representatives of Chief Minister, Treasury and Economic Development Directorate (CMTEDD) have been consulted and contributed to the planning and preparation of the Building 2/3 project business case.

External Consultation

34. A market sounding exercise was undertaken on the 12 and 13 February 2015 to inform the development of the Building 2/3 project business case. A range of construction contractors and equity and debt financiers (PPP sponsors) attended. Key points discussed included:

- market Interest, capability and capacity
- design considerations
- procurement approach
- timeframes and delivery program
- value for Money, Competitive Outcomes and Potential Incentive Mechanisms
- quality and whole of life considerations
- other issues – open questions.

35. Overall a positive response from the market was received. All participants in the process indicated interest and capacity for the project, with all asking or knowing that the government had not yet agreed to a funding commitment on the project.

36. Construction contractors indicated a preference for an ECI (two stage lump sum) delivery model given the staging and complexity of the brownfield site, however all indicated they would undertake the project by the delivery model determined by the Territory.

37. Equity and debit financers indicated that a PPP option is achievable for this project and that sourcing debit and equity would not be an issue in the current market. However concern was raised about the two phase approach and how this could be integrated within a PPP delivery model and how the extent of the scope for hard and soft facility management services would be managed, with it suggested that the entire Canberra Hospital campus may need to be considered within scope to avoid interface concerns.

Benefits/Sensitivities

38. Given the potential investment from Government in this project, the delivery model that is chosen will be subject to scrutiny.

39. At this time no decision has been made regarding the procurement delivery model option to be pursued for the Building 2/3 project. Under the Capital Framework, delivery model options have been initially considered, with two (PPP and ECI) ranked highest from a shortlist of options. These options will be analysed and assessed within the business case.

40. The delivery model chosen will be subject to Budget Cabinet consideration of the business case and any decisions that are made regarding funds availability, timing/staging of the project and associated benefits and risks of the models considered.

Media Implications

41. The Building 2/3 project has previously attracted media attention relating to the potential cost and timing of the project. It would be anticipated that a high level of media interest will exist in any Budget announcement regarding the project given the significant financial commitment and redevelopment proposed.

Recommendation

That you note the information contained in this brief.

Noted / Please Discuss

Simon Corbell MLA..... ...../...../.....

Minister's Comments

Signatory Name:	Paul Carmody	Phone:	X 50907
Title:	Deputy Director-General Health Infrastructure and Planning		
Date:	February 2015		
Action Officer:	Justin Barrett	Phone:	X 48004

ACT Government
Health

MINUTE

SUBJECT: Procurement Plan Variation for Commercial Advisory Services and the delivery of a Business Case for the Building 3 and 2 Redevelopment Project

To: Dr Peggy Brown, Director-General, ACT Health

Through: [redacted] Paul Carmody, Deputy Director-General, Health Infrastructure and Planning

From: Colm Mooney, Director, Procurement and Capital Works, Health Infrastructure

Date: 20 April 2015

Purpose

To seek approval to vary the current contract with KPMG to provide Commercial Advisory Services and the delivery of a Business Case for the Building 3 and 2 (B3/2) Redevelopment Project.

Background

On 23 December 2014 a Minute (COR14/15437) was approved by you to proceed with the single select procurement of KPMG to act as Commercial Advisor in the development of a Business Case for the B3/2 Redevelopment Project.

Following this a value for money assessment was conducted on KPMG's proposal to ensure it represented value for money for the Territory. On 3 February 2015 the Tender Evaluation Report for KPMG's submission was approved (COR15/779).

KPMG were instructed to commence with work and submitted a first draft Business Case on 23 February 2015 for review and comment by ACT Health. Subsequent revisions of the Business Case have been made with the latest received by ACT Health on 23 March 2015.

Given the original fee was based on a fixed schedule; the time allocated by the consultant has been expended. Additional allowance is required to complete the Business Case and incorporate comments by ACT Health and Treasury, unforseen at the time of KPMG's original proposal. ACT Health Project Director was informed by KPMG of the additional requirements which has led to a variation request being lodged on 19 March 2015.

Issues

As the original single select procurement exemption required approval by the Director-General ACT Health, a variation to this engagement also requires Director-General approval. A total of $40,000.00 (Ex GST) is required for the extra work completed to date.

The rates used in this variation are consistent with those approved under the relevant Commercial Advisors Panel Deed and are deemed to represent value for money for the Territory.

Appropriation is held within Clinical Services and Inpatient Unit Design and Infrastructure Expansion (CSIUDIE) for the B3/2 Proof of Concept and Preliminary Sketch Plans.

An allowance for the B3/2 Business Case and the proposed $40,000.00 (Ex GST) variation is made within this appropriation.

Recommendations

That you:

- Note the above information.

NOTED/PLEASE DISCUSS

- Sign page three of (Attachment A) the Procurement Plan (Variation) and agree to the variation of $40,000.00 (Ex GST) to KPMG's contract.

AGREED/NOT AGREED/PLEASE DISCUSS

.....

Dr Peggy Brown MBBS (Hons) FRANZCP
Director-General
27 April 2015

Colm Mooney
Director
Procurement and Capital Works, Health Infrastructure
April 2015

Action Officer: Peter Stringfellow
Extension: 47293

ACT Government Health

CORRESPONDENCE CLEARANCE

SUBJECT: Ministerial Brief - Status of Building 2-3 Redevelopment Business Case

NUMBER: COR15/2417 MIN 15/339 **DATE DUE:**

Director-General - Health Directorate: Date: 5/3/15

Deputy Director-General, Strategy & Corporate: Date:

Deputy Director-General, Canberra Hospital & Health Services: Date:

Deputy Director-General, Health Infrastructure and Planning: [redacted] Date: 5/3/15

Senior Manager, Ministerial and Government Services: Date:

Senior Manager, Communications and Marketing: [redacted] Date: 5/3/15

Chief Information Officer, E-Health & Clinical Records: Date:

Chief Finance Officer, Financial Management: Date:

Exec Director, Business and Infrastructure: Date:

Exec Director, Cancer, Ambulatory & Community Health Support: Date:

Chief Health Officer, Population Health: Date:

Exec Director, Critical Care: Date:

Exec Director, People, Strategy & Services: Date:

Exec Director, Medicine: Date:

Exec Director, Mental Health, Justice Health, Alcohol & Drug Services: Date:

Exec Director, Pathology: Date:

Exec Director, Performance Information: Date:

Exec Director, Policy & Government Relations: Date:

Exec Director, HealthCARE Improvement: Date:

Exec Director, Rehabilitation Aged & Community Care: Date:

Exec Director, Surgery, Oral Health & Medical Imaging: Date:

Exec Director, Women Youth & Children: Date:

Manager, Canberra Hospital Foundation: Date:

Director, Donate Life ACT: Date:

Exec Director, Clinical Support Services: Date:

Professional Leads: Date:

Other: Date:

Recommendations

That you:

1. Note the information contained in this brief;

Noted / Please Discuss

2. Agree that the draft Business Case be issued to Chief Minister Treasury and Economic Development Directorate for feedback prior to its finalisation.

Agreed / Not Agreed / Please Discuss

Simon Corbell MLA..... ...../...../.....

Minister's Comments

Signatory Name:	Paul Carmody	Phone:	X 50907
Title:	Deputy Director-General Health Infrastructure and Planning		
Date:	5 March 2015		
Action Officer:	Robyn Cross	Phone:	X 50431

ACT Government
Health

CORRESPONDENCE CLEARANCE

SUBJECT: Ministerial Brief - Benefits of Building 2-3 Redevelopment progressing to 30 percent Preliminary Sketch Plan stage

NUMBER: COR15/5400 / MIN15/739 **DATE DUE:**

Director-General - Health Directorate: Date: 25/5/15

Deputy Director-General, Strategy & Corporate: Date:

Deputy Director-General, Canberra Hospital & Health Services: Date:

Deputy Director-General, Health Infrastructure and Planning: [redacted] Date: 19/5/15.

Senior Manager, Ministerial and Government Services: [redacted] Date: 21/5

Senior Manager, Communications and Marketing: Date:

Chief Information Officer, E-Health & Clinical Records: Date:

Chief Finance Officer, Financial Management: Date:

Exec Director, Business and Infrastructure: Date:

Exec Director, Cancer, Ambulatory & Community Health Support: Date:

Chief Health Officer, Population Health: Date:

Exec Director, Critical Care: Date:

Exec Director, People, Strategy & Services: Date:

Exec Director, Medicine: Date:

Exec Director, Mental Health, Justice Health, Alcohol & Drug Services: Date:

Exec Director, Pathology: Date:

Exec Director, Performance Information: Date:

Exec Director, Policy & Government Relations: Date:

Exec Director, HealthCARE Improvement: Date:

Exec Director, Rehabilitation Aged & Community Care: Date:

Exec Director, Surgery, Oral Health & Medical Imaging: Date:

Exec Director, Women Youth & Children: Date:

Manager, Canberra Hospital Foundation: Date:

Director, Donate Life ACT: Date:

Exec Director, Clinical Support Services: Date:

Professional Leads: Date:

Other: Date:

ACT Government
Health

MINISTERIAL BRIEF

GPO Box 825 Canberra ACT 2601 | phone: 13 22 81
www.health.act.gov.au

UNCLASSIFIED

	TRIM No.: MIN15/739
To: Minister for Health	Date Rec'd Minister's Office 25/5/15

From: Dr Peggy Brown, Director-General ACT Health

Subject: Benefits of Building 2/3 Redevelopment progressing to 30 per cent Preliminary Sketch Plan stage

Critical Date: Not applicable

Critical Reason: Not applicable

Note

- DG Health 25/5/15
- DDG HIP .../.../...

No drawings to be progressed at this stage re 2/3 yet

Purpose

1. To provide background on redevelopment work completed to date on the Canberra Hospital campus - specific to the Building 2/3 Redevelopment Project, and seek approval to progress work to 30 per cent Preliminary Sketch Plan stage.

Mr to Head advised.

Background

2. The Health Infrastructure Program (HIP) is a program of redevelopment of health facilities developed in the context of planning to meet future demand for health services in the Territory through a network of services and facilities.

3. HIP projects have been identified through a process of services and capital planning that has determined when and where capital solutions are required to enable the implementation of new clinical technologies and models of care, and the projected increase in demand.

4. Services and capital planning in relation to the HIP have been subject to Cabinet consideration, and as a result of decisions of Cabinet, a series of update and review, as outlined below and at Attachment A and Attachment B.

5. The HIP incorporates projects from a program of works that have been completed, are underway or will be required at Canberra Hospital (CH): the Territory's tertiary hospital, Calvary Hospital: an acute general hospital, the University of Canberra Public Hospital (UCPH) which will provide subacute hospital services from 2018, and a range of Community Health Centres, a secure mental health unit and other facilities such as Clare Holland House.

6. HIP also includes an extensive program of works, both completed and underway, to ensure continuity of services until the redevelopment of the CH campus final solution is in place (staging and decanting), and that when required, infrastructure to support the increased service requirements (such as electrical supply and fire services) are also fully commissioned.

7. Of the broader CH campus redevelopment, a number of projects have already been completed, with these including the Adult Acute Mental Health Inpatient Unit, Centenary Hospital for Women and Children and Canberra Region Cancer Centre.

8. Specific to the forward design and construction of a future clinical services building activities completed to date include:

- Health Planning Unit (HPU - design) Briefs –significant work was undertaken on the HPU Briefs in 2009-2010, but these were placed on hold in 2010 when Government requested a review of the funding options available for the clinical services building redevelopment.

  In 2013 work recommenced on the review of these briefs. Given that the previous work was limited to consultation only with a small number of senior staff and did not extend to finalising and confirming complex models of care and service delivery with operational users (such as for the Ambulatory Care Centre), and as there had been a turnover of participants who comprise the user groups (clinicians, clinical support staff and consumer representatives) the ability to operationalise the briefs as drafted was reviewed and confirmed with senior users.

  There was also a need to reconfirm the principles, assumptions and planning 'givens' with these senior users. The suite of documents was endorsed in 2014-15. These briefs form part of the functional brief that directly informs the design process, as it identifies the key functional relationships between areas, the required accommodation/space requirements of each service and clinical area and any specific design considerations to ensure the model of care or service delivery for an area can be met.

- Future Facility Profile (FFP) – The Future Facility Profile was a desktop exercise to provide advice about whether alternate viable options existed for the redevelopment of Canberra Hospital. the FFP also considered the delivery of future redevelopment in "modular" funding commitment blocks, or viable smaller projects that would, together, form a final reconstruction of essential clinical services infrastructure, but be able to be constructed as separate components as funding becomes available. As part of this work, the concept master plan for the development of the main clinical blocks at the Canberra Hospital was created. Of the three options for consideration by the FFP (outlined in Attachment B), one (Keep Safe and Operating) was not viewed as viable. The supported option provided for a phased approach to development.

- Building Audit - Building condition audits of Buildings 1, 10 and 12 at CH were undertaken from March 2014, with a detailed report received in August 2014. The report provided details on the existing condition of building structure, fabric and services associated with these assets, including projected costs to maintain, upgrade or redevelop the assets over the next 25 years.

  The report also provided advice on suitable future uses for these buildings.
  The report was used to inform the Proof of Concept, and consideration of potential uses for these builidngs within this.

- Proof of Concept (POC)- The POC was a process that tested design assumptions outlined in the Future Facility Profile and proposed a building design solution. Completed in September 2014 by specialist health architects Silver Thomas Hanley (STH) the POC was required to inform the proposed redevelopment.

  The POC provides a flexible staged building design solution that can adapt to changing models of care and allow for future expansion.

  The proposed design solution also allows for the redevelopment of Buildings 2 and 3 to be delivered within two phases, with multiple stages within each of these phases also possible.

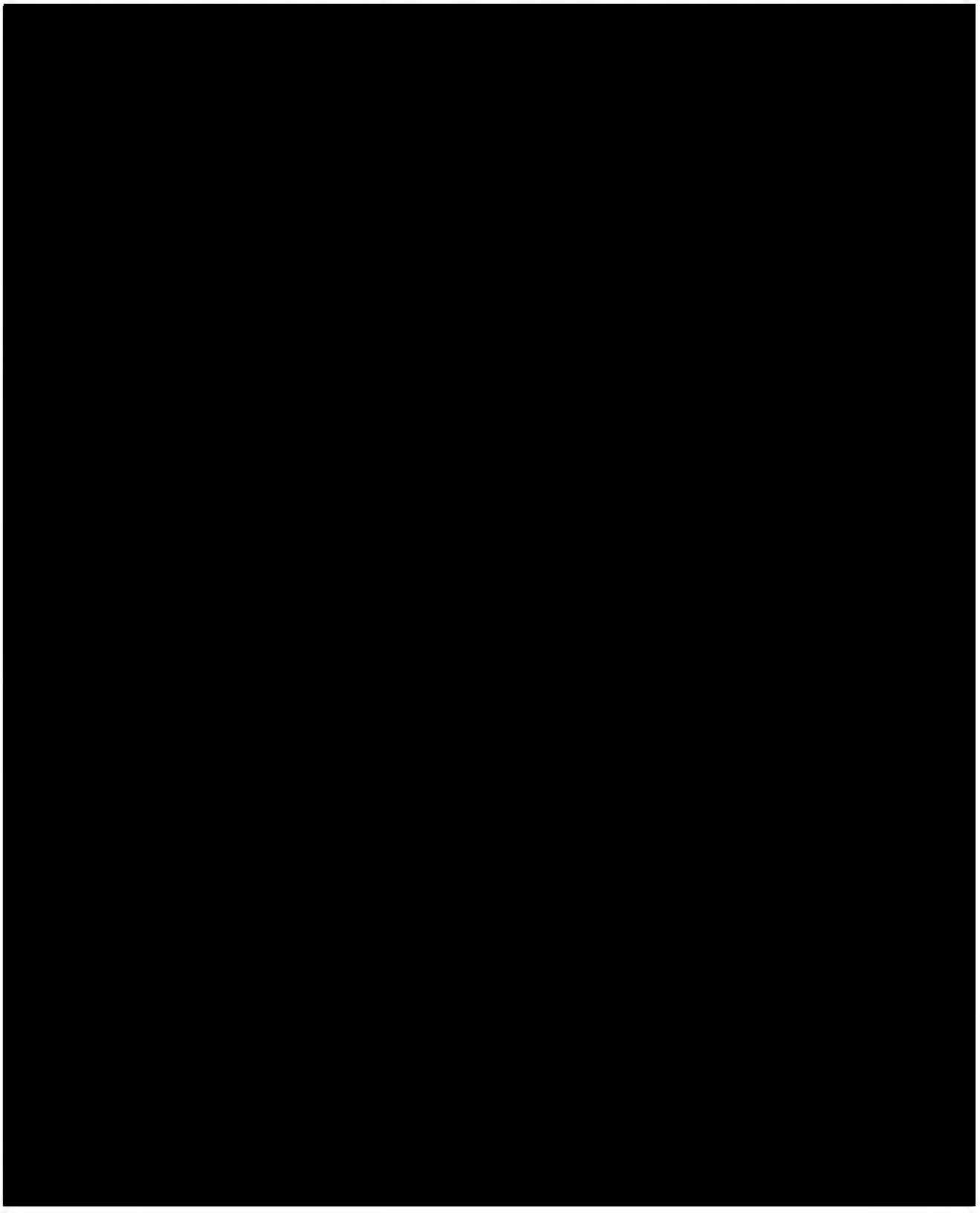
  Phase One is the demolition of the existing Building 3 and the construction of a new building consisting of a podium and tower building, with Phase Two involving the demolition of Building 2 and subsequent construction of a new facility with a podium and tower.

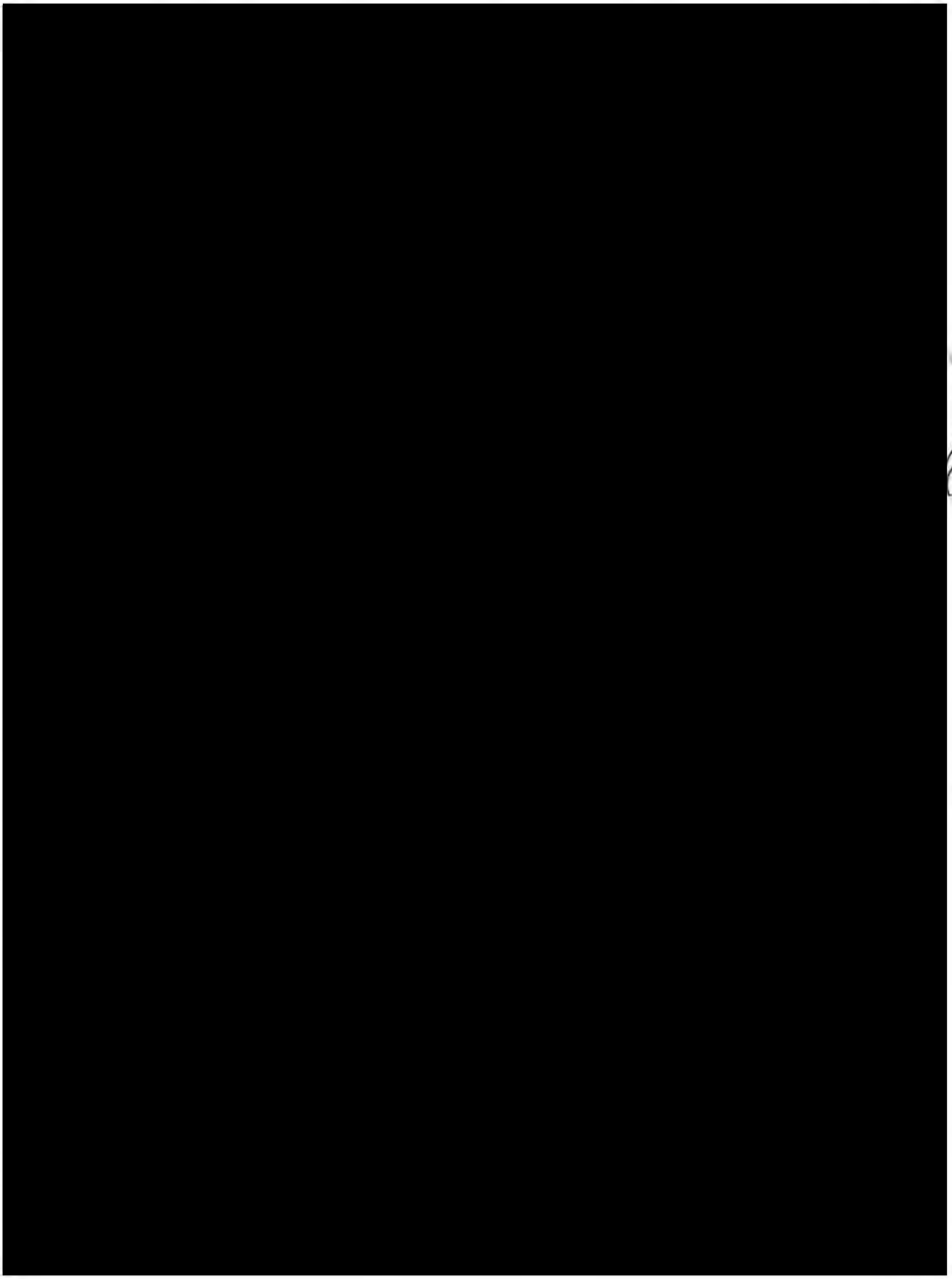
  The phased approach allows for the existing Tower Block (Building 1) to be retained as long as possible and for the new clinical services building to accommodate growth and clinical areas with the most significant changes in delivery models foreshadowed in the short-medium term.

9. The scope of work for STH also included the development of the Preliminary Sketch Plans (PSP) for the expansion/refurbishment of the existing ED and to progress design of the clinical services building development to PSP.

10. As at 1 May 2015, ACT Health is in a position to progress to using the work completed to date to progress to 30 per cent Preliminary Sketch Plan (PSP) to provide a concept, or reference design.

[redacted]





[redacted]

Financial Implications

27. To date Government has made a significant investment towards the redevelopment of the CH campus, and the Building 2/3 project more specifically. This includes appropriations that have directly funded work to support the Building 2/3 redevelopment, and appropriations that have funded infrastructure and staging and decanting works to position ACT Health to progress the Building 2/3 project while maintaining continuity of services on the campus. Funding to prepare the 30 per cent PSP is provided in the above appropriations. The cost to prepare the 30 per cent PSP is in the order of $590,000, GST inclusive.

Directorate Consultation

28. Significant consultation has occurred with Chief Minister, Treasury and Economic Development Directorate officials with regard to the proposed Building 2/3 project, procurement options and business case.

29. A range of consultation has also occurred across government, specific to subject matter expertise, to inform work completed to date on the facility planning process for the Building 2/3 project.

External Consultation

30. To date, other than consultants directly engaged to support the Building 2/3 project, the only external consultation that has occurred with regard to the project was a market sounding process undertaken in February 2015 to inform the development of the business case. This was separately briefed at the time (MIN15/173).

Benefits/Sensitivities

31. The need for ACT Health to be in a position to meet future health service demand is acknowledged, with HIP and the CH campus redevelopment supported as a response to this. However, some projects within the HIP have attracted criticism within the Legislative Assembly in relation to the time, scope and cost of works. Specific to the Building 2/3 project, a focus has been given on the final design and timing of the project .

32. Staff, consumers and other key stakeholders have invested significant time and resources in the facility planning process to inform the design of Building 2/3. For some, this is the second time this process has been undertaken. There is a need to nurture this engagement. Depending on the procurement option selected, engaged user groups will be required to inform the design process during an interactive bidding process.

33. The planning of public health services is undertaken on a Territory wide basis, taking into account cross-border and private industry activity. The HIP, similarly reflects a Territory wide response of networked health services inclusive of tertiary acute, general acute, sub-acute and community based services. Given the investment required for the Building 2/3 project, there is a risk of focussing solely on a single project, rather than as a component of a network of health services.

Media Implications

34. It would be anticipated that any delays in the construction of the Building 2/3 project would attract media attention, as it has previously done so and most recently the progress of the project has been queried within the Legislative Assembly.

Recommendations

That you:

1. Note the information contained in this brief; and

Noted / Please Discuss

2. Agree to ACT Health progressing the Building 2/3 project to 30 per cent Preliminary Sketch Plan stage.

Agreed / Not Agreed / Please Discuss

Ms Fealey - pls discuss

Simon Corbell MLA..... 4/6/15

Minister's Comments

Signatory Name:	Paul Carmody	Phone:	X 50907
Title:	Deputy Director-General Health Infrastructure and Planning ACT Health		
Date:	May 2015		
Action Officer:	Robyn Cross	Phone:	X 50431

ACT Government Health

MIN12/2334

CORRESPONDENCE CLEARANCE

SUBJECT: Options for Developing Clinical Services Buildings at the Canberra Hospital under the Health Infrastructure Program - Continuity of Services B32 schedule final

NUMBER: COR12/13261 **DATE DUE:**

Director-General - Health Directorate: Date: 20/12/12

Deputy Director-General, Strategy & Corporate: per [redacted] Date: 17/12/12

Deputy Director-General, Canberra Hospital & Health Services: Date:

Director, Executive Coordination: [redacted] Date: 17/12/12

Director, Communications and Marketing: Date:

Chief Information Officer, E-Health & Clinical Records: Date:

Chief Finance Officer, Financial Management: Date:

Exec Director, Business and Infrastructure: Date:

Exec Director, Capital Region Cancer Service: Date:

Chief Health Officer, Population Health: Date:

Exec Director, Critical Care & Diagnostics: 3.40pm Date:

Exec Director, People, Strategy & Services: Date:

Exec Director, Medicine: Date:

Exec Director, Mental Health, Justice Health & Alcohol & Drug Services: Date:

Exec Director, Pathology: Date:

Exec Director, Performance & Innovation: Date:

Exec Director, Policy & Government Relations: Date:

Exec Director, Quality & Safety Unit: Date:

Exec Director, Rehabilitation Aged & Community Care: Date:

Exec Director, Service & Capital Planning: [redacted] Date: 17/12/12

Exec Director, Surgery & Oral Health: Date:

Exec Director, Women Youth & Children: Date:

Professional Leadership Research & Education: Date:

Manager, Canberra Hospital Foundation: Date:

Medical Director, Donate Life ACT: Date

Manager, Internal Audit & Risk: Date:

Operational Support: Date:

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20 DEC 2012
in Chief Minister's Office

ACT Government
Health

MINISTERIAL BRIEF

GPO Box 825 Canberra ACT 2601
Website: www.health.act.gov.au
ABN: 82 049 056 234

To: Katy Gallagher MLA, Minister for Health

Subject: Options for developing Clinical Services Buildings at the Canberra Hospital under the Health Infrastructure Program

Through: Stephen Goggs, A/Deputy Director-General, Strategy & Corporate

Dr Peggy Brown, Director-General 20/12/12

Critical date and reason

N/A

Purpose of Brief

To recommend options for the program to redevelop the main clinical buildings at the Canberra Hospital in the context of continuity of service provision and the potential impacts on the Territory's financial position.

Background

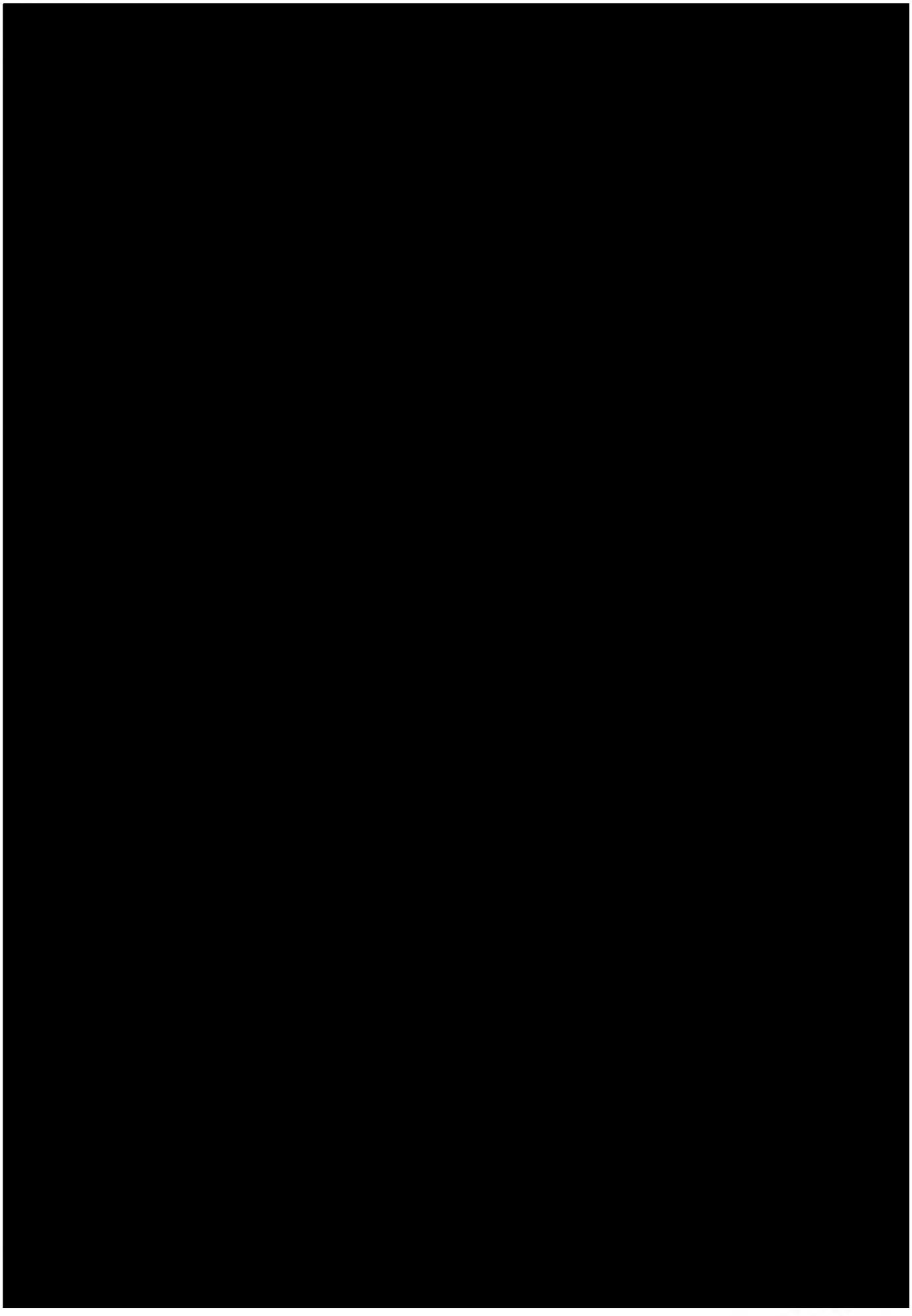
2. The Health Infrastructure Program (HIP) is the implementation of the Capital Asset Development Plan (CADP) that proposed an integrated public health system which will:

   i. meet rapidly growing demand for hospital and community health services; and

   ii. facilitate the implementation of new models of care that maximise the responsiveness, accessibility and efficiency of clinical services in the ACT through an integrated hospital and community health service network.

3. In May 2008 the Government announced a "$1 billion plus" commitment to a 10 year program of capital works then known as the CADP. There have been subsequent appropriations and a number of early projects such as the Centenary Hospital for Women and Children, Gungahlin Community Health Centre, the Southern Car park and the Adult Mental Health Unit have been completed. Further projects including the Canberra Region Cancer Centre and Belconnen Enhanced Community Health Centre have commenced.

4. The planning for the full form and scope of the HIP has continued to be developed. As advised in 2011 there has been a high degree of confidence in demand projections for the short to medium term, the longer term projections have higher degrees of uncertainty. To counter this, demand projections have continued to be reviewed and revised, so that the success of the introduction of new models of care and preventative and treatment strategies, or unforeseeable trends in clinical activity, for example, can be incorporated into calculations. Inpatient demand projections to 2022 have been reviewed in 2012, using more recent actual activity data and applying the previously agreed assumptions about the ability to implement hospital avoidance strategies etc. There has been little movement from the earlier projections.



Forward Design new Clinical Buildings at TCH

11. Budget of $41m was appropriated in 2011-12 for the design of enhanced hospital facilities at the Canberra Hospital, including the replacement and redevelopment of infrastructure needed to support a sustainable health system to ensure the safety, availability and viability of quality health care in the ACT.

12. Under the current program, Final Sketch Plans for new Buildings 2 & 3 would be completed in November 2014 and construction would commence in November 2015. Construction of Building 3 would be completed in June 2018, with services operating from the new building in late 2018.

13. Construction of new Building 2 is programmed to be completed in 2021.

14. These timeframes assume Budget appropriation for documentation in 2014-15, and construction in the 2015-16 Budget, for Building 3.

15. Under this program, the design team would be appointed in January 2013. Negotiation is currently continuing with a preferred tenderer.

16. The scope for the design is based on the phased approach to delivering new clinical services Buildings 3, 2 and 1 at Canberra Hospital as approved by Cabinet in November 2011.

17. The design brief also incorporates feasibility studies to determine the feasibility of utilising existing buildings 1 (the Tower block) and 10 (Pathology).

18. Continuity of Services planning has identified the quantum of the incremental demand for hospital based services to 2022 (the outyear for the HIP).

19. The projection for the Canberra Hospital assumes investment in growth at Calvary, and the delivery of the UCPH in 2017. This timeframe may need to be revised outward depending on the delivery method determined for the UCPH project.

20. Bed occupancy has been modelled at 85% which is the agreed occupancy rate for general inpatient areas (areas such as Intensive Care Unit have a 75% occupancy rate modelled to cater for the need to accept urgent admissions). Current bed occupancy in ACT public hospitals is generally higher than 95%.

Staging and Decanting

21. The Staging and Decanting (S&D) Strategy has been developed to ensure the availability of infrastructure to meet health services demand during the planned infrastructure program.

22. Budget of $41.7m has been appropriated for staging and decanting over the 2011-12 to 2013-14 financial years. This will provide design and construction funding to relocate and rehouse clinical and non clinical services across the Territory to meet agreed HIP project delivery and bed growth demand projection. Some of the major project deliverables will be the relocation of up to 200 administrative staff to Curtin (Former Emergency Services Agency building), the creation of additional bed spaces in the tower block at TCH by returning office space into ward space, the refurbishment of major ward space vacated by the creation of the new Centenary Hospital for Women and Children on levels 4 and 5 of the tower block and over 30 various other smaller projects including decanting staff into the new health centres.

23. Future capital bids for S&D funding will be necessary to complement ongoing HIP project delivery.

Issues

24. There has been no Government decision to fund progression to construction of new Buildings 3 and 2, or the design of new Building 1.

Depreciation

25. Existing buildings will be depreciated at an accelerated rate from the time a decision is made to demolish them to zero value by the end of the decanting process. This is a significant financial consideration additional to the investment in the construction of the buildings.

26. Depreciation will need to be completed prior to this point because the buildings will theoretically have been determined to no longer be fit for purpose.

27. The value of the buildings at 30 June 2013 was:

Building 1	$106,212,703
Building 2	$ 12,851,266
Building 3	$ 83,432,820 (including Radiation Oncology, which is to be retained)

28. If not demolished the current depreciation schedule would see Building 1 progress to zero value by 2046, Building 2 by 2054 and Building 3 by 2072.

Cost of Stage 2 TCH

29. The first phase (confirmation and validation) of the Building 3 & 2 design process (six months from appointment of the design team) will inform a decision as to the best way to deliver these buildings in the context of the Master Plan for TCH. This work undertaken in the first six months will provide more robust costings of the project in the context of a brownfields construction on an operating hospital campus, maximising continuity of services and minimising disruption to service delivery. The completion of Preliminary Sketch Plans in the following six months will confirm the ability to design a solution for the new buildings. A recommendation on funding the demolition of the existing Building 3 and construction of the new building would be able to be made based on this more robust context.

Options for Continuity of Clinical Service Provision

30. In the context of the significant impact of this project on the Territory's financial position, two options have been developed for ensuring continuity of service delivery, and particularly the ability to meet projected increasing demand for services, at the Canberra Hospital. The options include:

    Option 1
    Proceed as planned to implement the phased approach to delivering new Buildings 3, 2 & 1 at TCH; or

    Option 2
    Update the Canberra Hospital Master Plan and delay the implementation of the redevelopment of the main clinical buildings (3, 2 & 1) at TCH, subject to consideration of the options resulting from the revision of the campus Master Plan.

31. Each option assumes the currently planned delivery of beds under the Staging and Decanting Plan. Attachment A summarises the implications for the availability of acute inpatient beds under various options, assuming an occupancy rate of 85 % which reflects best practice planning.

32. Option 2 offers an alternate, financially responsible and flexible option, given the current financial environment and that the redevelopment is to occur on a brownfields, operational hospital site. Under this option, the Master Plan for the Canberra Hospital campus would be reviewed with the intent of delivering a Master Plan that provides for future redevelopment in more manageable commitment blocks. The scope would seek advice on viable smaller projects that would, together, form a final reconstruction of essential clinical services infrastructure, but be able to be constructed as separate components as funding is made available. Revision of the Master Plan would incorporate investigation into the feasibility of better utilising existing buildings 1 (the Tower block) and 10 (Pathology).

33. An updated Master Plan would also provide information to underpin decisions about the feasibility of options for ongoing staging and decanting to ensure continuity of services and response to increasing demand for hospital services.

34. In summary, the estimation of supply/deficit of beds shows, in addition to the impacts of demolishing and then redeveloping Buildings 3, 2 and 1 at TCH, the dependency on simultaneous development at Calvary, the commissioning of UCPH and, importantly, the provision of additional beds at TCH under the S&D Plan.

35. The modelling is only indicative for bed supply in Building 1, showing an additional 67 beds in new Building 1, however the planned feasibility study will show the possible options for redevelopment of the area that Building 1 occupies, and future planning will determine need.

36. There is risk associated with the assumption underpinning projections of bed supply that there will be continuing cooperation from Calvary to achieve increased bed numbers within the required timeframe. If this incremental increase in beds at Calvary is not achieved, there will be significant pressure on hospital beds under any of the options.

37. While small deficits between projected demand for, and supply of, acute hospital beds can be addressed theoretically by operating at a higher bed occupancy during redevelopment, reliance on this, in the context of demand projections being estimations based on best available evidence rather than predictions of actual activity would be a strategy with high risk. It will be essential to continue with the S&D Plan, to frontload the available bed supply to preclude the risk of significant periods of acute hospital bed supply deficit. Option 2 may provide for the commissioning of UCPH before the demolition of Building 3 and longer periods of acute bed supply certainty in conjunction with the S&D planning.

38. It will be important to develop the S&D Plan to ensure that investment is made in infrastructure that can be retained for as long as possible with maximum effect in enhancing key clinical areas.

39. Previous advice has noted that acute and sub-acute hospital facilities are not interchangeable. Delivering UCPH before demolishing Building 3 was not recommended in the 2011 Cabinet Submission because the strategy would delay commencement of redevelopment of TCH and have a number of serious limitations, including:

    i. extending the period of interim/redundant facilities until an adequate supply of permanent clinical services are provided;

    ii. the risk of service demand for both acute and sub and non-acute hospital services exceeding physical capacity;

    iii. the risk of serious infrastructure breakdown (and clinical service disruption) on the Canberra Hospital campus due to ageing capital stock;

    iv. stakeholder dissatisfaction due to perceived non action on the TCH Master Plan and a view that TCH has been superseded by the northside facilities. This perception could also contribute to difficulties in attracting and retaining appropriate clinical staff, particularly at TCH;

    v. extending the period whereby Health Directorate is unable to fully implement clinical/service change via new models of care; and

    vi. extending the period of the redevelopment increasing the capital cost due to escalation.

40. You noted in presenting the Submission to Cabinet in 2011 that delays in commencing the design of the long term, permanent clinical services solutions for the Territory's public hospitals will lead to requirements for additional interim services to meet growing demand and the potential for demand to exceed the physical capacity to provide services.

41. The implications of not expanding key clinical facilities would be felt both in acute, as well as sub- and non- acute services. In the acute hospitals particularly there will be a significant shortfall in ED, ICU and Outpatients capacity if no expansion is undertaken, and this would result in risk of increased ED and Outpatient waiting times, as well as a decrease in access to elective surgery due to insufficient ICU beds and not expanding the Day Surgery Unit. Option three has been formed to address these concerns.

42. An updated campus Master Plan with provision for smaller staged sections of redevelopment will allow the prioritisation of design and construction of 'high pressure' infrastructure such as an extended ED, which requires not only expansion but significant redesign to enable it to operate safely and efficiently to meet activity targets, as funding becomes available.

43. One of the consequences of implementing Option two, however, would be a potentially extended period of onsite construction.

44. In addition to progressing with revision of the campus Master Plan, Option two would also allow the use of the current appropriation for enhanced TCH clinical facilities to commence projects to address immediate clinical capacity issues such as the expansion of maternity inpatient accommodation, addressing work flows in the ED, the construction of the secure mental health unit or commencing design of additional car parking capacity at TCH.

Media

A decision to delay the planned construction of the new buildings at Canberra Hospital may attract media attention, particularly in respect of pressures on the ED and delivering new infrastructure to support new models of care and new technologies.

Recommendations

That you:

- note that a decision about the appointment of a Principal Consultant to design new Buildings 3 & 2 at Canberra Hospital will need to be made in mid January 2013 to meet the current programme for completion of construction of the building in 2018;

AGREED/NOT AGREED/NOTED/PLEASE DISCUSS

- note the financial issues associated with continuing with the planned program for construction of the new Buildings 3 & 2 at Canberra Hospital;

AGREED/NOT AGREED/NOTED/PLEASE DISCUSS

- note the advice above about options for continuity of hospital services in the medium term;

AGREED/NOT AGREED/NOTED/PLEASE DISCUSS

- agree to the completion of an updated Master Plan for the Canberra Hospital campus; and

AGREED/NOT AGREED/NOTED/PLEASE DISCUSS

- agree to delay the implementation of the redevelopment of Buildings 3 and 2 at Canberra Hospital indefinitely, subject to consideration of the options resulting from a revision of the campus Master Plan.

AGREED/NOT AGREED/NOTED/PLEASE DISCUSS

Grant Carey-Ide
Executive Director
Service & Capital Planning

as discussed at the meeting on 22/1/12

Action Officer: **Jacinta George**
Phone: **50525**

..... / /
Katy Gallagher MLA

K. Gallagher

Hospital Bed Demand (work in progress, as at 16 November 2012)

		Demand @ 85%, Current HIP outyear												assuming same rate of growth						
Hosp	Acute/Rehab	2010_11	2011_12	2012_13	2013_14	2014_15	2015_16	2016_17	2017_18	2018_19	2019_20	2020_21	2021_22	22_23	23_24	24_25	25_26	26_27	27_28	28_29
CH	Acute	174	181	187	194	200	207	215	224	234	245	256	269	279	291	302	314	327	340	354
	Rehab	26	26	27	27	28	28	29												
	Total	200	207	214	221	228	236	244	224	234	245	256	269	279	291	302	314	327	340	354
TCH	Acute	435	448	462	476	491	507	524	542	561	582	603	625	646	668	691	714	738	763	788
	Rehab	66	66	66	66	66	67	67												
	Total	500	513	528	542	558	574	590	542	561	582	603	625	646	668	691	714	738	763	788
UCPH	Rehab								98	100	102	104	107	109	112	114	117	119	122	124
Total Acute/Rehab		700	721	742	763	786	809	834	864	895	928	963	1,001	1,035	1,070	1,107	1,145	1,184	1,224	1,266

Supply SQ

							+L4/5, -B3			+UCPH	+B3N		-B1, +B2N		+B1N					
	Hosp	Acute/Rehab	2010_11	2011_12	2012_13	2013_14	2014_15	2015_16	2016_17	2017_18	2018_19	2019_20	2020_21	2021_22	22_23	23_24	24_25	25_26	26_27	27_28	28_29
	CH	Total	177	177	184	199	215	230	240	283	283	283	283	283	283	283	283	283	283	283	283
	TCH	Total	466	468	503	530	557	580	580	565	974	974	609	609	662	662	662	662	662	662	662
	UCPH	Rehab								144	144	144	144	144	144	144	144	144	144	144	144
	Total ACT Health		643	645	687	729	772	810	820	992	1,401	1,401	1,036	1,036	1,089	1,089	1,089	1,089	1,089	1,089	1,089
variance SQ	Hosp	Acute/Rehab	2010_11	2011_12	2012_13	2013_14	2014_15	2015_16	2016_17	2017_18	2018_19	2019_20	2020_21	2021_22	22_23	23_24	24_25	25_26	26_27	27_28	28_29
	CH	Total	-23	-30	-30	-22	-13	-6	-4	59	49	38	27	14	4	-8	-19	-31	-44	-57	-71
	TCH	Total	-34	-45	-25	-12	-1	6	-10	23	413	392	6	-16	16	-6	-29	-52	-76	-101	-126
	Total TCH/CH		*-57*	*-76*	*-55*	*-34*	*-14*	*1*	*-14*	*82*	*462*	*431*	*33*	*-2*	*19*	*-14*	*-48*	*-83*	*-120*	*-158*	*-197*
	UCPH	Rehab	0	0	0	0	0	0	0	46	44	42	40	37	35	32	30	27	25	22	20

Supply HIP paused 2 yrs

							+L4/5	+L4/5	+L4/5	-B3, +UCPH			+B3N		-B1, +B2N		+B1N			
	Hosp	Acute/Rehab	2010_11	2011_12	2012_13	2013_14	2014_15	2015_16	2016_17	2017_18	2018_19	2019_20	2020_21	2021_22	22_23	23_24	24_25	25_26	26_27	27_28	28_29
	CH	Total	177	177	184	199	215	230	240	283	283	283	283	283	283	283	283	283	283	283	283
	TCH	Total	466	468	503	530	590	608	646	569	569	569	972	972	609	609	662	662	662	662	662
	UCPH	Rehab								144	144	144	144	144	144	144	144	144	144	144	144
	Total ACT Health		643	645	687	729	805	838	886	996	996	996	1,399	1,399	1,036	1,036	1,089	1,089	1,089	1,089	1,089
variance +2yrs	Hosp	Acute/Rehab	2010_11	2011_12	2012_13	2013_14	2014_15	2015_16	2016_17	2017_18	2018_19	2019_20	2020_21	2021_22	22_23	23_24	24_25	25_26	26_27	27_28	28_29
	CH	Total	-23	-30	-30	-22	-13	-6	-4	59	49	38	27	14	4	-8	-19	-31	-44	-57	-71
	TCH	Total	-34	-45	-25	-12	32	34	56	27	8	-13	369	347	-37	-59	-29	-52	-76	-101	-126
	Total TCH/CH		*-57*	*-76*	*-55*	*-34*	*19*	*29*	*52*	*86*	*57*	*26*	*396*	*361*	*-34*	*-67*	*-48*	*-83*	*-120*	*-158*	*-197*
	UCPH	Rehab	0	0	0	0	0	0	0	46	44	42	40	37	35	32	30	27	25	22	20

Supply HIP paused 5 yrs

							+L4/5	+L4/5	+L4/5	+UCPH			-B3			+B3N		-B1, +B2N		+B1N	
	Hosp	Acute/Rehab	2010_11	2011_12	2012_13	2013_14	2014_15	2015_16	2016_17	2017_18	2018_19	2019_20	2020_21	2021_22	22_23	23_24	24_25	25_26	26_27	27_28	28_29
	CH	Total	177	177	184	199	215	230	240	283	283	283	283	283	283	283	283	283	283	283	283
	TCH	Total	466	468	503	530	590	608	646	687	687	687	569	569	569	972	972	609	609	662	662
	UCPH	Rehab								144	144	144	144	144	144	144	144	144	144	144	144
	Total ACT Health		643	645	687	729	805	838	886	1,114	1,114	1,114	996	996	996	1,399	1,399	1,036	1,036	1,089	1,089
variance +5yrs	Hosp	Acute/Rehab	2010_11	2011_12	2012_13	2013_14	2014_15	2015_16	2016_17	2017_18	2018_19	2019_20	2020_21	2021_22	22_23	23_24	24_25	25_26	26_27	27_28	28_29
	CH	Total	-23	-30	-30	-22	-13	-6	-4	59	49	38	27	14	4	-8	-19	-31	-44	-57	-71
	TCH	Total	-34	-45	-25	-12	32	34	56	145	126	105	-34	-56	-77	304	281	-105	-129	-101	-126
	Total TCH/CH		*-57*	*-76*	*-55*	*-34*	*19*	*29*	*52*	*204*	*175*	*144*	*-7*	*-42*	*-74*	*296*	*262*	*-136*	*-173*	*-158*	*-197*
	UCPH	Rehab	0	0	0	0	0	0	0	46	44	42	40	37	35	32	30	27	25	22	20

Min13/628

ACT Government
Health

Sharon,
I need a Meeting just on This topic with health and/or the consultants to this report
maybe 4/5 pm tomorrow?
@ PMD next week.

To: Katy Gallagher MLA, Minister for He

Subject: Options for redevelopment of the Ca Program

Through: Dr Peggy Brown, Director-General
Ian Thompson, Deputy Director-Ge
Ron Foster, Chief Finance Offic

Critical date and reason

N/A

Purpose of Brief

To provide options and a recommendation for progressing the redevelopment of Canberra Hospital in the context of the Health Infrastructure Program.

Background

2. The Health Infrastructure Program (HIP) is a program of redevelopment of health facilities developed in the context of planning to meet future demand for health services in the Territory through a network of services and facilities.
3. HIP projects have been identified through a process of services and capital planning that has determined where capital solutions are required to enable services to meet projected increased demand and to implement new clinical technologies and approaches and new models of care.
4. The HIP incorporates projects from a comprehensive program of works that have been undertaken, or will be required, at Canberra Hospital (TCH): the Territory's tertiary hospital, Calvary: an acute general hospital, the University of Canberra Public Hospital (UCPH) which will provide subacute hospital services from 2017, and a range of Community Health Centres, a secure mental health unit and other facilities such as Clare Holland House and the Queen Elizabeth II Family Centre.
5. The program also includes an extensive schedule of works to enable continuity of services until the redevelopment's final solution is in place.
6. MIN 12/2334 (**Attachment D**) recommended, inter alia, that the Canberra Hospital Master Plan be updated against the context of renewed or new contextual information made available since Cabinet considered HIP funding options in 2011 and determined that a staged approach be undertaken to the redevelopment of the Canberra Hospital infrastructure.
7. Information that has been updated or become available since the Cabinet decision in 2011 includes the 2012 Calvary Master Plan, continuity of services planning around acute hospital demand and supply, the HIP Staging and Decanting Plan, and facilities and infrastructure recently delivered and in construction.
8. MIN 12/2334 also recommended that the implementation of the redevelopment of buildings 3 and 2 at Canberra Hospital be delayed, subject to consideration of the options resulting from a revision of the campus Master Plan.

9. A Future Facility Profile (FFP) for the Canberra Hospital campus has been undertaken, incorporating a concept Master Development Plan. The *TCH Future Facility Profile Report* (Aurora Projects 20 February 2013) is attached (**Attachment A**). The development of the FFP considered the delivery of future redevelopment in "modular" funding commitment blocks, or viable smaller projects that would, together, form a final reconstruction of essential clinical services infrastructure, but be able to be constructed as separate components as funding becomes available.
10. The FFP has considered demand projections, the planning for the Staging and Decanting project and the upgrade of campus infrastructure.
11. The three options considered in the FFP are:

    Option 1: Continue with the planned project, with the delivery of major clinical infrastructure planned to be incorporated in new buildings 3 and 2 (including Emergency Department, new inpatient units, Ambulatory Care Centre and Medical Imaging) as one capital project to be phased by Principal Consultant.

    Option 2: Retain the existing infrastructure with development limited to essential engineering infrastructure replacement.

    Option 3: Implement a revised concept plan, or schema, for new buildings 3, 2 and 1 infrastructure, phased to enable modular delivery of components as funding becomes available in time to meet future demand.

12. Option 3 is a phased approach to the development of Canberra Hospital consistent with the general staging schema for the campus submitted with Cabinet Submission 11/225, **(Attachment B)**, although the timeframe for implementation of any of the options now differs from that in attachment B.
13. The phasing proposed under Option 3 is the sequential development, as demand requires and as funding allows, of the main clinical building:

    Phase 1(a): Podium for new Building 3 inpatient Towers 1&2, and construction of Tower 1;

    Phase 1(b): Construction of Tower 2; and

    Phase 2: Construction of the Building 2 podium and construction of Tower 3.

14. As noted in Cabinet Submission 11/225, and the preceding Cabinet Submission 10/0383, redevelopment at Canberra Hospital has been planned in the context of meeting future demand for health services in the Territory through a network of services delivered from new or redeveloped facilities. Interim and full redevelopments at the Canberra Hospital have been planned to provide capacity in combination with the development of the University of Canberra Public Hospital and expansion at Calvary Hospital, as well as expansion of community based services.
15. It is recommended that the Design for Option 3 commences in 2013/14, following procurement of a Principal Consultant, and completion of both the Proof of Concept of the schema and study of the feasibility of existing Building 1 for planned use. Demolition of Building 3 would commence in 2014/15 and Phase 1 construction would be complete at the end of 2018/19, with commissioning by the end of 2019.

[redacted]

[redacted]

Proof of Concept

18. The FFP has been a desktop exercise to inform advice to you about whether alternate viable options exist for the redevelopment of TCH. The exercise would be required to proceed to proof of concept/validation (the stage to which the current Buildings 3 and 2 project was to proceed next prior to Preliminary Sketch Plan) to confirm viability of the approach as proposed, and more firm program and cost estimates. The Recommendations in Section 6 of the FFP outline the approach that should be taken to fully test the feasibility of the recommended option.

Need for additional infrastructure at the Canberra Hospital

19. In addition to provision of inpatient beds, phase 1 of Option 3 will also provide the ability to increase the capacity of other critical infrastructure, including Intensive Care Unit beds to meet demand by 2019, Medical Imaging and Emergency Department capacity, as well as relocation of the Helipad to enable space to be released for further car parking capacity.
20. Activity projection modelling has identified that in 2013/14 an additional 8 Emergency Department assessment spaces are required above those planned in the project currently in construction stage, with an annual increase of around 2.5 spaces required.
21. An additional 3 Intensive Care Unit beds, beyond those included in the expansion project currently being constructed, will be required in 2017/18 (with an annual increase in bed numbers to 2022).
22. Growth in Ambulatory Care clinics to 2019 could be catered for in new Community Health Centres.
23. Future demand for additional overnight beds is dependent on a combination of actual demand, and the ability to bring planned beds online through the Staging and Decanting project, the release of beds at both Calvary and Canberra Hospitals when UCPH opens, and the availability of beds at Calvary when the private hospital on the Calvary site is commissioned. Additional beds will be required to be commissioned by 2022/23 to meet demand beyond these measures. A minimum four year design/demolition/construction period will be required.
24. A major advantage of a new design for clinical infrastructure will be the enabling of increased efficiencies in processes and facilities.

Forward Capital Works Program

25. The estimated four year capital works funding requirement is at **Attachment C**. The timeframe for Calvary developments is yet to be agreed.

Procurement of Design Services

26. The Government Solicitor's Office [redacted]

Analysis of Options

27. Table 1 below summarises the key distinctions between the three options in terms of provision for continuity of services.
28. The FFP confirms previous advice to Cabinet that Option 2 (development limited to essential engineering infrastructure replacement) is not viable because the existing buildings at Canberra Hospital will not be able to meet the requirements of projected demand to 2021/22.
29. The limitations of the existing infrastructure in terms of expansion space, and the ability to accommodate changing models of care and required upgrades to the level of infrastructure that is required to run a modern health facility, including identified site engineering infrastructure limitations, are discussed in Section 3.2 of the FFP.

30. The cost to replace essential engineering infrastructure at the Canberra Hospital, not including appropriations already made, is estimated at approximately $34 million.

31. There are a number of sub options within Option 3 reflecting varying degrees of retention of existing infrastructure for longer periods. For example, Option 3(a) proposes building 5 levels of inpatient wards in the first tower block constructed, but only fitting out three in the first instance. Option 3(b) proposes, in addition, to shell the basement level but not fit out for hotel services in the first instance.

32. The advantages of implementing Option 3(a) over Option 1 include:

    - Implementation of the recommended schema will allow the Emergency Department to be expanded earlier, retaining it in Building 12, with expansion into Building 1.
    - The option to adjust staging of subsequent phases of construction through significant re-use of current buildings, such as retaining the Emergency Department in Building 12, with expansion, and utilising current wards in Building 1 until funds become available to replace them with new infrastructure.
    - The Intensive Care Unit could be commissioned with expanded capacity as planned, in 2019.
    - The flexibility to respond to increases in demand beyond 2022 by the planned construction of an additional tower on the established podium of the new Building 3, followed by building the podium and tower for new Building 2.
    - Easier access to the hospital and campus with the Main Entry from Yamba Drive.
    - The flexibility to close Hospital Road between the current Building 15 and National Capital Private Hospital in the future to expand the clinical precinct toward the east of campus.
    - The Helicopter pad will be able to be relocated to the top of the first tower block to be constructed, allowing for the commencement of a northern car park before 2019.

Table 1: Summary of Options response to Continuity of Services requirements

Requirement	Option 1	Option 2	Option 3
Emergency Department expansion to meet projected demand	Quarter 1 2020	✗	Quarter 1 2019 (Phase 1)
Intensive Care Unit expansion to meet projected demand	Quarter 1 2020	✗	Quarter 1 2019 (Phase 1)
Ability to accommodate new technologies and models of care and service delivery	✓	✗ limited	✓
Enable relocation of helipad within clinical precinct to enable commencement of northern car park construction in time to address projected demand	✗	✗	✓
Capacity to expand "clinical precinct"	?*	✗	✓
Reuse of existing infrastructure (with renovation) for clinical offices	moderate	N/A	Major
Reuse of current theatres	possible	N/A	Yes
Retain and use Building 1 existing ward stock	minimal	N/A	Yes
Option to adjust staging as funds become available	?*	N/A	✓

*Not available given existing Master Plan, however Principal Consultant may develop, if briefed, as an option during proof of concept/validation.

Recommended Option

33. It is recommended that procurement for a Proof of Concept of Option 3(a) proceed in 2012/13, allowing construction of Phase 1 to be complete in 2018/19. The following works are able to be undertaken within current appropriation.

(i) Proof of Concept/Validation and Forward Design to completion Preliminary Sketch Plan for Phases 1, 1(b) and 2: **Estimated $20 million**

(ii) Proof of concept for the Emergency Department (planning program of capital works that together form the final schema for the ED (in B12, expanding into B1) to meet demand for 2022: **Estimated $ 1 million**

(iii) Capital Works/Early Works to Emergency Department, combined with paediatric streaming project: **Estimated $18 million**

(iv) Study of Feasibility of Existing Building 1 for planned use: **Estimated $ 1 million**

TOTAL Stage 1: $40 million

Funding Implications

34. Table 2, below, presents a summary of the differences in costs of Option 1 and Option 3(a).

35. The major factors contributing to the lower estimated cost of Option 3(a) over Option 1 include:

- All ward spaces will be retained in existing Building 1 until additional beds are required (unless funding becomes available to decant them to new Tower 2 or new Tower 3).
- The majority of offices will be in refurbished space, most likely on eastern side of campus, (unless funding becomes available to build new stock).
- This option reuses all existing operating theatres.

36. It was identified during the development of the FFP that it is no longer necessary to factor a Central Energy Plant into the HIP because new infrastructure such as the Centenary Hospital for Women and Children has included standalone energy infrastructure. The new buildings 3 and 2 will also incorporate energy infrastructure.

37. The costings do not include costs for compliance with 5 star Greenstar accreditation.

38. Funding options will also consider accelerated depreciation, which has not been included in the analysis of options in the FFP. The value of the section of Building 3 that will be demolished under Phase 1 of Option 3(a) is estimated at $72 million.

39. The implementation of the recommended option will need to be supported by continuation of Staging and Decanting and Campus Infrastructure projects.

40. Additional appropriation will be required to complete Final Sketch Plan and construct Phase 1 and, when demand requires, Phases 1(b) and Phase 2.

Table 2: Summary of the differences between the current program (Option 1) and the alternate (Option 3)

Facility/scope	Budget $ '000	Program commence design	Program construction complete
Option 1 *proceed as planned*	[redacted]	2013/14	New Building 3: 2019/20 New Building 2: 2022
Option 2 *essential engineering infrastructure replacement*			
TOTAL Option 3a			
Option 3a Phase 1		2013/14 *(B3 current demolished in 2015)*	2018/19
Option 3a Phase 1 (b)}		2013/14	2020/21 (or as required)
Option 3a Phase 2 }			As required

All options are net of current or former appropriations.

* Any changes to construction commencement and completion dates will result in escalation additional to the figures above for each Option.

Media

There will be media interest in the future HIP.

Recommendations
That you:

- Agree to the commencement of proof of concept/validation studies in relation to progressing Option 3(a) for the redevelopment of major clinical infrastructure at the Canberra Hospital, as outlined in the *TCH Future Facility Profile Report* (Aurora Projects 20 February 2013), and planning for capital works to expand the Emergency Department.
  AGREED/NOT AGREED/NOTED/PLEASE DISCUSS

- Agree to the commencement of procurement in 2012/13 of a Principal Consultant to undertake the design (including Proof of Concept of the Option 3(a) schema and design for early works to expand the Emergency Department into Building 1 within existing appropriation.
  AGREED/NOT AGREED/NOTED/PLEASE DISCUSS

- Agree to the continuation of work on the Master Plan for Calvary Hospital to develop more robust timeframes within which capital works, other than the car park for which funding has been sought in the 2013/14 Budget, are required.
  AGREED/NOT AGREED/NOTED/PLEASE DISCUSS

Grant Carey-Ide
Executive Director
Service & Capital Planning

Action Officer: Jacinta George
Phone: **50525**

Katy Gallagher 21/5/13
Katy Gallagher MLA

ACT Government
Health

MINUTE

SUBJECT: Location of Interventional Cardiology in New Building 3/2

To: Ian Thompson, Deputy Director General, Canberra Hospital and Health Services

Through: Walter Abhayaratna, A/g Executive Director, The Division of Medicine

From: Jacinta George, Senior Manager Health Services Planning Unit

Date: 19 May 2015

Purpose

To advise Executive Director of the Division of Medicine and Deputy Director-General Canberra Hospital and Health Services of ongoing concerns raised by Dr Ren Tan relating to the proposed location of the Cardiac Interventional Suite in the New Building 3/2.

Background

The Interventional Suite Health Planning Unit Brief specifies that co-location of a range of services, including the Cardiac Catheter Laboratory will:

- eliminate duplication of specialised equipment
- utilise skilled staff effectively
- promote patient-centred care.

The co-location of interventional services is desirable to provide a safe patient environment for the management of all patients requiring general anaesthetic and post anaesthetic care.

Issues

The clinical leadership team from Cardiology have raised concerns about the effects of separating the Cardiac Catheter Laboratories and Electro-Physiology Studies Laboratory from the inpatient Coronary Care ward. The Cardiology ward is briefed to be co-located with the Cardiothoracic/Thoracic surgical Inpatient Unit.
Specific issues include:

- Risk of adverse patient outcome related to potential transport delays when accessing the Cath Lab in an emergency situation from CCU
- Inefficient workflows due to the high percentage of patients who are cared for in CCU pre and post anaesthetic

The Facility Planning team have provided the following assurances in the Brief:

- Direct (< 2 mins) access from the CCU Inpatient Unit to the Interventional floor and vice versa, via 6 patient dedicated lifts provisioned with a lift call override option
- dedicated unit staff for timely patient transport in the case of an emergency
- the location of a number of day beds, a holding bay and Stage 1 and 2 Recovery Areas proposed within the Interventional space to facilitate efficient elective patient flow

Feedback was sought through NSW Health Infrastructure Branch about the location of the CCU and CCL in other similar health facilities in NSW:

- Royal North Shore Hospital has co-located all Interventional Suites on the one floor (Level 4) and the Cath Labs are located 2 floors below the inpatient unit (Level 6). The feedback from that facility is that this works well.
- St George Hospital is about to undergo a facility redevelopment. The plan is to locate the Cath Lab one floor below the Acute Coronary Care Unit.
- Westmead Hospital Cath labs are currently located by themselves with little or no integration with either theatres or critical care beds. Planning is underway to improve connection between the labs and CCU beds.

Health Services Planning Unit (HSPU) staff are happy to participate in any conversations arranged by the Division of Medicine to resolve this issue.

Recommendation

That you:

- That advice is provided about whether Canberra Hospital and Health Services requires an amendment to the HSPU Brief based on the concerns of clinical staff as noted above.

AGREED/NOT AGREED/NOTED/PLEASE DISCUSS

.....

Ian Thompson
Deputy Director-General Canberra Hospital and Health Services
May 2015

Name Jacinta George
Title Senior Manager
Branch Health Service Planning
Division Health Infrastructure and Planning

Date: 19 May 2015

Action Officer: Karen O'Brien
Branch: Health Service Planning Unit
Extension: 6174 8037
Email: Karen.obrien@act.gov.au

No 118

Select Committee on Estimates
2015 – 2016 Budget

17 June 2015

Canberra Hospital – New Clinical Services Buildings (Buildings 2 and 3)

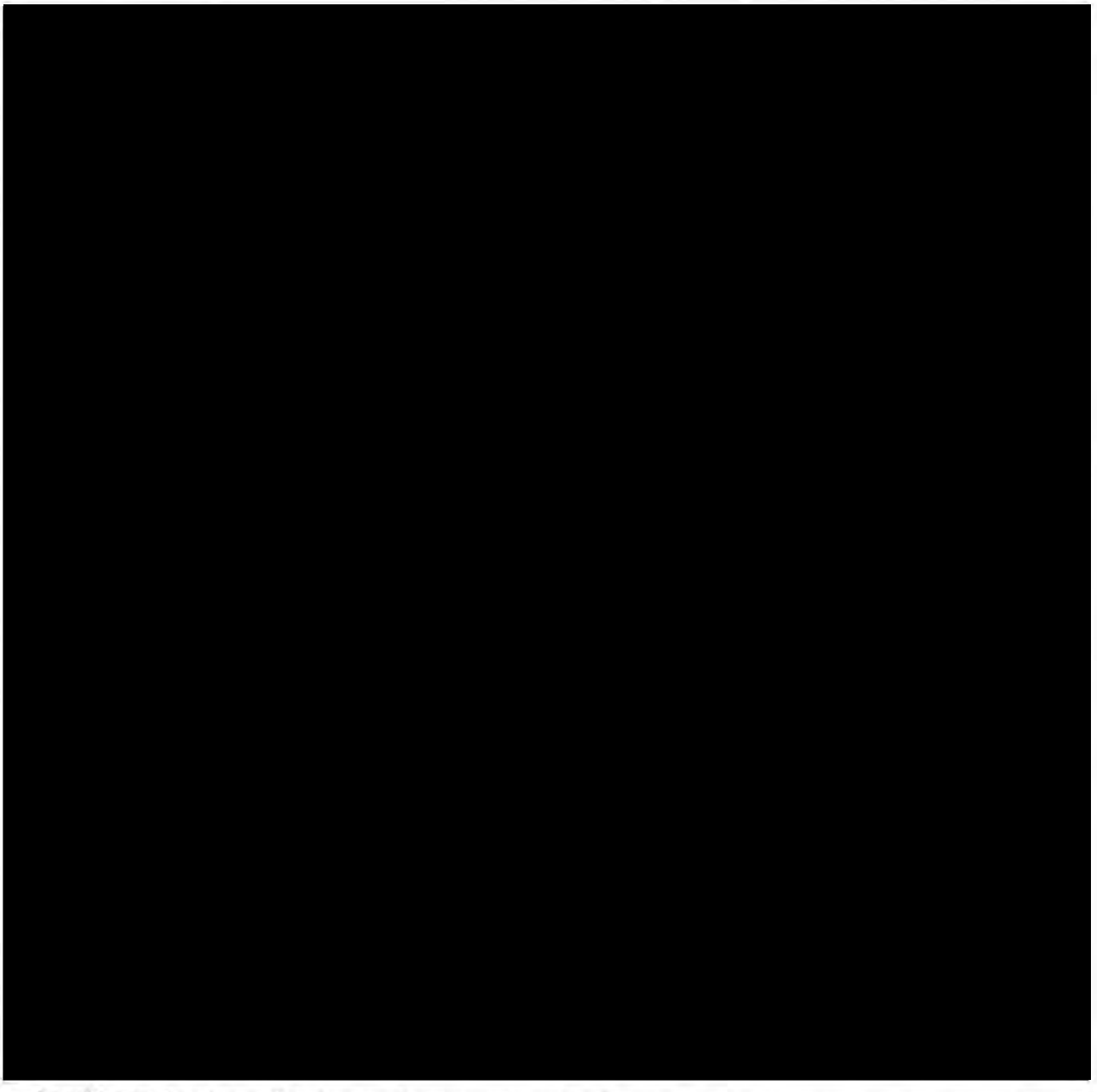
Key Points

- After consideration of the Business Case for the redevelopment of Buildings 2 and 3 at Canberra Hospital into a new clinical services building in the 2015/16 Budget round, Government determined that further work was required – with this to be progressed jointly by an ACT Health and Chief Minister, Treasury and Economic Development Directorate (CMTEDD) Taskforce.
- In May 2015, the Terms of Reference for an ACT Health/CMTEDD Taskforce were agreed, with work commencing in the same month to review the investment logic and feasibility of any proposed project solutions and to develop a business case for consideration in the 2016/17 Budget.
- The Taskforce will develop and assess the needs and options for health infrastructure at Canberra Hospital including alterative options, procurement approach, recurrent and capital cost implications, funding strategies and the potential for private sector delivery of health services.
- As part of the business case development to be undertaken by the Taskforce, ACT Health has commenced a process to review the principles, methodology and planning assumptions that underpin the Health Infrastructure Program. An independent consultancy will be engaged to support this work. The focus of the review will be on public health services Territory wide, acknowledging the network of public health facilities and services that exist. A significant component of this work will include identification of demand management strategies not already utilised, and identification of any alternatives to infrastructure solutions.
- In parallel with the activities of the Taskforce, ACT Health is progressing the program of work for the new clinical services building to the 30 per cent Preliminary Sketch Plan (PSP) stage, with a concept or reference design being the deliverable.
- Completion of the 30 per cent PSP, is expected in September 2015, and will test if the right space of the right size to enable efficient operational flow to provide the required patient centred care has been achieved.
- The delivery of a concept or reference design will ensure the work completed to date can be realised in an early design, without compromising the procurement option that may be chosen for the redevelopment. The reference design will ensure that the functional relationships and requirements to support the identified models of care are accurately reflected. Completion of the 30 per cent will mitigate the risk of a major rework of the facility planning process in the future – at a cost of time, resources and consultant fees. By progressing to 30 per cent PSP, agreement can be reached on the early design and validated

against the Proof of Concept, minimising the risk of work being repeated at a later date, or, as has been seen on some interstate projects, a lack of ownership by senior and influential clinicians.

- The 30 per cent PSP will be used by the Taskforce to inform their consideration of the preferred project option for the redevelopment of a new clinical services building.

Background



Specific to the forward design and construction of a future clinical services building, activities completed to date include:

- Health Planning Unit (HPU - design) Briefs –significant work was undertaken on the HPU Briefs in 2009-2010, but these were placed on hold in 2010 when Government requested a

review of the funding options available for the clinical services building redevelopment, with a full review and confirmation of these briefs recommencing in 2013.

- Future Facility Profile (FFP) –this was a desktop exercise to provide advice about whether alternate viable options existed for the redevelopment of Canberra Hospital. As part of this work, the concept master plan for the development of the main clinical blocks at the Canberra Hospital was created. The supported option from the FFP provided for a phased approach to development.

- Building Audit - Building condition audits of Buildings 1, 10 and 12 at Canberra Hospital were undertaken from March 2014, with a detailed report received in August 2014. The report provided details on the existing condition of building structure, fabric and services associated with these assets, including projected costs to maintain, upgrade or redevelop the assets over the next 25 years.

  The report also provided advice on suitable future uses for these buildings.
  The report was used to inform the Proof of Concept, and consideration of potential uses for these buildings within this.

  Proof of Concept (POC) - The POC was a process that tested design assumptions outlined in the Future Facility Profile and proposed a building design solution. Completed in September 2014 by specialist health architects Silver Thomas Hanley (STH) the POC was required to inform the proposed redevelopment.

  The POC provides a flexible staged building design solution that can adapt to changing models of care and allow for future expansion. The proposed design solution also allows for the redevelopment of Buildings 2 and 3 to be delivered within two phases, with multiple stages within each of these phases also possible.

Contact: Paul Carmody Phone: 620 50907