CAMPBELLTOWN HOSPITAL REDEVELOPMENT
LEADING MACARTHUR TO BETTER HEALTH

ROOT PARTNERSHIPS
Advisory+
Project Management

NSW GOVERNMENT Health Infrastructure

Campbelltown Hospital Redevelopment (CHR)

Phase 1 - Planning

Project Management Plan (PMP)

Issue date: April 2018

CONTENTS

Version	Date	Issued To	Status
V-OC	October 2017	HI	For Review
V-OD	October 2017	HI	Amended following HI comments
V-OE	December 2017	HI	Updated for period
V-OF	February 2018	HI	Updated for Period
V-OG	March 2018	HI	Updated for Period and Final Business Case
V-OH	April 2018	HI	Update for Period

1. Reference: Commonly Used Acronyms

BLP	Billard Leece Partnership (Architect)
LHD	Local Health District
CRG	Clinical Reference Group
CWG	Communications Working Group
C&CP	Communications and Consultation Plan
ESC	Executive Steering Committee
EUG	Executive User Group
FB	Functional Brief
FF&E	Fixtures, Furniture & Equipment
HI	Health Infrastructure
HI SPPG	Health Infrastructure Standards, Policies, Procedures and Guidelines
PDC	Planning & Development Committee
PDP	Project Definition Plan
PDT	Project Delivery Team
PM	Project Manager
POE	Post Occupancy Evaluation
POFP	Process of Facility Planning
PPT	Project Planning Team
PUG	Project User Group
PWG	Project Working Group
RP	Root Partnerships (Project Manager)

2. Introduction

Campbelltown Hospital is a major metropolitan group B1 hospital, co-located with a mental health in-patient service. It is the major partner in a clinical services network with Camden Hospital providing a range of emergency, medical, surgical, maternity, intensive care, renal and other health services at mainly Role Delineation Level 4 to the Macarthur region of South Western Sydney.

The existing Campbelltown Hospital facilities are at capacity with significant increases in service demand projected by 2027/28 (acute inpatient presentations projected to increase by 73%, Emergency Department presentations by 62% and non-admitted occasions of service by 97%).

The Stage 1 redevelopment completed in early 2016 provided additional inpatient beds, enhancements to the ED including Emergency Short Stay Unit, maternity services and paediatrics; co-located ambulatory care, outpatients, antenatal and allied health consulting rooms and treatment spaces; provided expanded pathology, clinical information spaces and loading dock; and provided additional car parking.

The Stage 2 redevelopment includes the construction of new buildings as well as refurbishment of existing buildings to provide major enhancement of the emergency department, additional operating theatres, additional medical and surgical inpatient beds, an expansion of the intensive care unit, an expansion of out-patients, additional renal dialysis facilities as well as new and expanded mental health facilities and an expansion and enhancement of paediatric services, and improvements to supporting services and infrastructure.

This project is specifically for **the Stage 2 redevelopment – Phase 1 – Planning.**

This detailed planning phase will investigate how this scope will be delivered within the available budget to meet project objectives.

The updated cost estimate for the Stage 2 redevelopment project is $632m, plus an additional amount (c$35M) for an early works multi-storey car park stage. Civil Secure Unit and Older Persons Mental Health is subject to separate funding.

3. Purpose of the Project Management Plan

The purpose of the Project Management Plan (PMP) is to describe the project scope and set out the way the project will be delivered in terms of:

- Describe the scope and objectives of the project;
- Describe the governance structure and reporting;
- Describe who the key stakeholders are and their roles and responsibilities; and
- Describe the methods and tools used to monitor and control and report on time, cost, quality, change, risk, safety and design.

3.1 Document Control

The PMP is treated as a live document is required to be regularly updated so that is stays relevant. The Project Manager (PM) will review the PMP once a month or as changes occur. Changes to the PMP will be recorded in the Document Control box with the new revision number and date and by who the update was made.

3.2 Consultant Service Delivery Plans

This PMP is deemed to be same as the Service Delivery Plan (SDP) for The PM. Therefore, submission of the PMP is deemed to satisfy the requirements to deliver a SDP.

The SDP for the Architect and the Cost Manager are included in the Appendix 1 & 2.

4. Related Documentation

4.1 Project Information Documentation

The following list of documents is related to the project and was used to complete the PMP:

- RFT Capital Consultant Section 1 to 5 inclusive. August 2014, V1.2. Issued July 2017.
- Root Partnerships Tender Submission (RFT No. HI17219), Campbelltown Hospital Stage 2 Redevelopment - Envelope 1 and 2. Dated 27 July 2017.
- Preliminary Business Case incorporating the requirements of a Service Procurement Plan Version 1.4, September 2014.
- Campbelltown Hospital Masterplan Report September 2014, Rev C
- Campbelltown Hospital Feasibility Design Report, November 2014, Rev B
- Campbelltown Hospital Investment Decision Document, 12 May 2017.
- Abridged Clinical Services Plan for Macarthur to 2031, Final 26 May 2017
- Campbelltown Hospital Redevelopment Stage 2, Mental Health and South West Paediatric Service - Project Governance Arrangements Template, August 2017
- HI Process of Facility Planning – Guidelines for Projects valued $10million and above. V3.0, 26 May 2010.
- Campbelltown Hospital Redevelopment – Stage 2, Communications and Consultation Plan, V02, October 2014

4.2 HI SPPGs and Templates

The HI Standard Policies, Procedures and Guidelines (SPPGs) have been followed and all HI templates will be used for submitting documents back to HI where applicable. Access to the HI Portal is via approval from HI.

Note: To resolve issues in accessing the HI Portal please contact [redacted]

5. Project Definition

5.1 Project Scope Overview

Health Infrastructure NSW (HI) has engaged Root Partnerships (RP) to partner with HI and the SWSLHD to provide project management services, to deliver Phase 1- Planning, of the Campbelltown Hospital Redevelopment Stage 2 Project (Project). It was agreed through governance that the project abbreviation is “CHR”.

Phase 1 – Planning includes:

- completion of clinical planning;
- site and building master planning;
- the preparation of the schematic design (which includes the process of Clinical Design Development brought back from Phase 2);
- the preparation of a Business Case (based on concept design level documentation) for December 2017 (draft version) to confirm the investment proposition in the *NSW Investment Decision Paper (May 2017);*
- the town planning application in 2018.
- the engagement also includes an *option* for PM services to deliver the construction of the Early Works (Phase 2 – Implementation) through to June 2018.

RP is to provide full project management services and provide health facility planning services (for which we have partnered with Carramar Consulting). The intent being that the CHR Project is ready and approved for immediate progression to *Phase 2 - Project Implementation* (which is subject to a separate procurement process) from June 2018 onward.

Campbelltown Hospital Stage 1 was completed in early 2016 and the hospital has now secured initial investment decision support for Stage 2 CHR Project. The CHR Project will address capacity shortfalls for many key clinical and support services including ED, mental health, paediatrics, interventional suits, and intensive care.

The service drivers include high population growth, growing population of children, growing population of older people, high levels social-economic disadvantage, high burden of preventable disease (population health) and high demand for acute mental health services proportional to population growth with increased presentations to the ED. Campbelltown Hospital requires an increase in built-infrastructure capacity to provide safe, quality and timely care and to enable self-sufficiency to reverse patient outflows to adjoining regions that are within the capability (role delineation) of the hospital.

The whole of the redevelopment is to be within a budget of $632m, plus an additional approx. $35m for an early works multi-storey car park stage.

The project options development phase will consider a range of built solutions including the delivery of new build with optimal reuse of, and connectivity to, existing facilities.

5.2 Project Objectives and User Requirements

The Project Objective is to continue the development of Campbelltown Hospital to meet the evolving service needs as identified in the *Abridged Macarthur Clinical Services Plan to 2031* and *the Enhanced Paediatrics Capacity Plan to 2031.*

This includes a number of specific supporting objectives, including to:

- Deliver an appropriate implementation / phasing plan for the project
- Address agreed clinical priorities
- Align with the LHD strategic and health care services plan
- Enable current / new models of care and clinical innovation
- Attract and retain best workforce
- Provide a platform for research
- Provide a platform for education and training
- Provide safe, effective, patient focussed care to deliver improved patient outcome
- Improve overall operational efficiency of the service

- Maximise efficiency in site utilisation
- Provide for future development
- Optimise the investment in new infrastructure
- Align with the approved master plan
- Engage with the community
- Strengthen strategic partnerships e.g. primary care providers, university
- Align benefits realisation with the LHD's KPIs
- Achieve principal referral status.

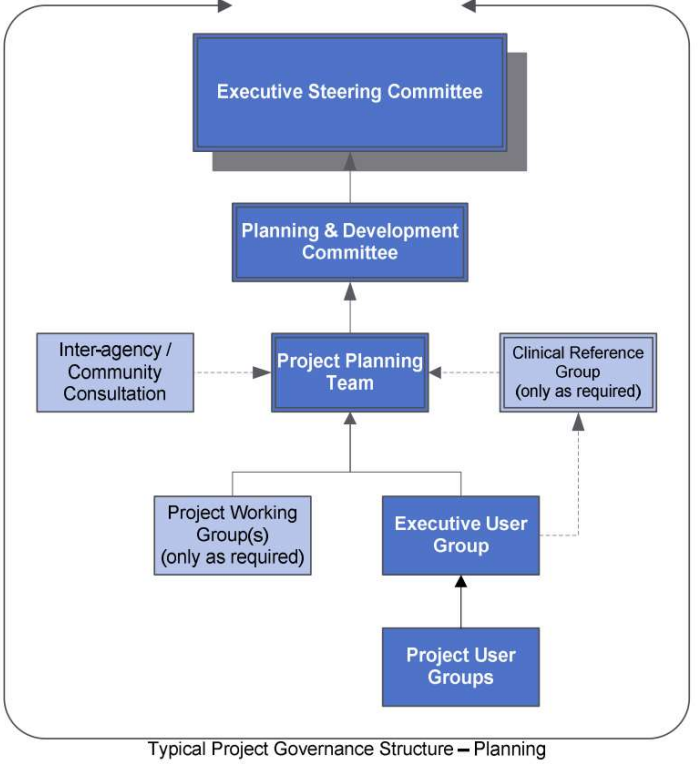
RP is to provide the project management Services in accordance with the Process of Facility Planning (POFP), NSW Government Gateway Review Process, and HI Project Delivery Standards.

6. Project Governance Structure

The following diagram and list below shows the typical Governance Structure and groups that will be convened for this Project.

- Executive Steering Committee (ESC)
- Planning & Development Committee (PDC) (Planning)
- Project Planning Team (PPT)
- Project Working Group(s) (PWGs)
- Executive User Group (EUG)
- Clinical Reference Group (CRG)
- Project User Group(s) (PUGs)

Governance Structure for Planning



Typical Project Governance Structure – Planning

The Project Governance Structure for the initial phase of the project was established to respond to the particular timing and deliverables for the project. This phase broadly comprises:

- finalisation of the Clinical Services Plans (CSPs)
- clinical review and validation
- master planning
- options development (including Value Management Study)
- concept design
- preparation of the Business Case

The typical Project Governance Structure has now been implemented for this project.

6.1 Project Committee Meetings

Executive Steering Committee (ESC)

The ESC provides strategic direction and leadership on all Project activities, monitoring achievement of project deliverables (including adherence to Project scope) and endorsing project deliverables prior to submission to HI, MoH or Treasury in the case of Gateway review documentation.

The ESC is the ultimate decision-making authority within the Project Governance Structure. The ESC comprises of delegated executives from those stakeholders responsible for delivering the Project within the agreed scope. Where issues or variations have been escalated, the ESC will form a recommendation with regard to project scope, budget, or compliance with the Australasian Health Facility Guidelines (AusHFGs) or completion of POFP deliverables for consideration by the Secretary of NSW Health, HI Chief Executive or the AusHFG Steering Committee.

The ESC is also responsible for providing strategic advice to the Project related to Whole of Government issues and policies.

The ESC provides overall Project direction, strategic advice and leadership; consider political, social or relevant regional commentary around sentiment towards the Project and advice regarding strategic long-term considerations and evaluation of broader redevelopment issues. See Governance Terms of Reference in Appendix 3.

Planning and Development Committee (PDC)

During Parts 0-3 of the HI POFP, the PDC is responsible for monitoring and advising on all aspects of the Project, monitoring the achievement of project deliverables for which Stakeholders are responsible as outlined in the POFP (including adherence to Project scope and parameters, making decisions consistent with their level of delegation, providing direction and advice to other governance structures), and endorsing project deliverables prior to submission to the ESC.

The PDC oversees the planning of a Project until Contractor appointment. The key deliverables monitored by the PDC typically include, as amended to suit the particulars of the project, the Service Procurement Plan (SPP), Preliminary Business Case (PBC), Project Definition Plan (PDP) and the Business Case (BC). The PDC also monitors other key activities such as the development of key strategies such as operational and workforce strategies and change and communication strategies. The PDC monitors overall program and project requirements within budget, time and scope.

6.2 Project Meetings

A number of meetings are required in order to manage and control the project. These include:

Project Planning Team (PPT)

The PPT is responsible for early planning for operations and implementation to facilitate the achievement of Project objectives as defined the Service Procurement Plan (SPP) / Preliminary Business Case (PBC) and subsequently the Project Definition Plan (PDP) / Business Case (BC). The role of the PPT includes the interface with Project Working Groups (PWGs), Project User Groups (PUGs), and monitoring and/or implementing key operational and clinical strategies which support the POFP including risk management, change management (including operational policies and models of care), communications, operation and commissioning (including non-clinical support services, systems and equipment).

The PPT is responsible for the consideration and coordination of the consultation processes and engagement with users. The PPT reviews key activities and provides advice to the PWGs, EUG, PUGs and PDC/PCG on clinical and non-clinical issues in order to facilitate, co-ordinate, guide and advise the project as required. *The PPT will be established when the project commences the Schematic Design phase.*

Executive User Group (EUG)

The EUG is responsible for overseeing the PUG process. This includes resolving issues escalated from PUGs and ensuring consistency across each PUG and alignment with design briefs with the Clinical Services Plan (CSP), local, area and state-wide, LHD and Facility operational policies and other project parameters. The EUG is also responsible for endorsing design briefs and design documents prior to submission to the PPT or PDT for endorsement. *The EUG will be established when the project commences the Schematic Design phase.*

Clinical Reference Group (CRG)

A CRG is convened as required to provide expert clinical advice on clinical and health service delivery matters to the PDC/PCG or PPT. This group is responsible for the resolution of clinical issues escalated from the PUGs.

Clinical Reference Working Group (CRWG)

The CRG is supported by the Clinical Reference Working Group (CRWG) which provides clinical input to develop and propose outcomes for specific clinical and operational matters.

Project User Groups (PUGs)

The PUGs are specific to clinical, clinical support and non-clinical support services. The PUGs members are hospital and health service staff and consumer representatives particular to each of the service groups and departments. The PUGs have been formed to inform the development of the Functional Design Brief (FDB) and the Schematic Design phase.

Expert Reference Group (ERG)

The ERG provides expert input (industry and subject matter experts) to review development aspects of the project. The ERG has been formed and provided review of:

- The Master Plan and Concept Design of multi-storey car park
- The whole of site Master Plan (site strategic master plan).

6.3 Cross Project Interface Planning and Management

There are several interfacing projects with CHR. They are:

- The Multi-Storey Car Park (MSCP) project, this will become an early works project. The governance of this project will come under this Phase 1 Planning governance.
- The Older Persons Mental Health Unit will be addressed in the Statewide Mental Health Program business case. The planning assumption is that the funding for the Older Persons Mental Health unit will be provided from other sources, however the unit is to be planned as an integral part of the overall solution
- Civil Secure Unit (CSU). This is a separate project that will also be addressed by the Statewide Mental health Program business case. .

6.4 Meeting Schedule

The following key meetings are to be established and conducted throughout the duration of the Project:

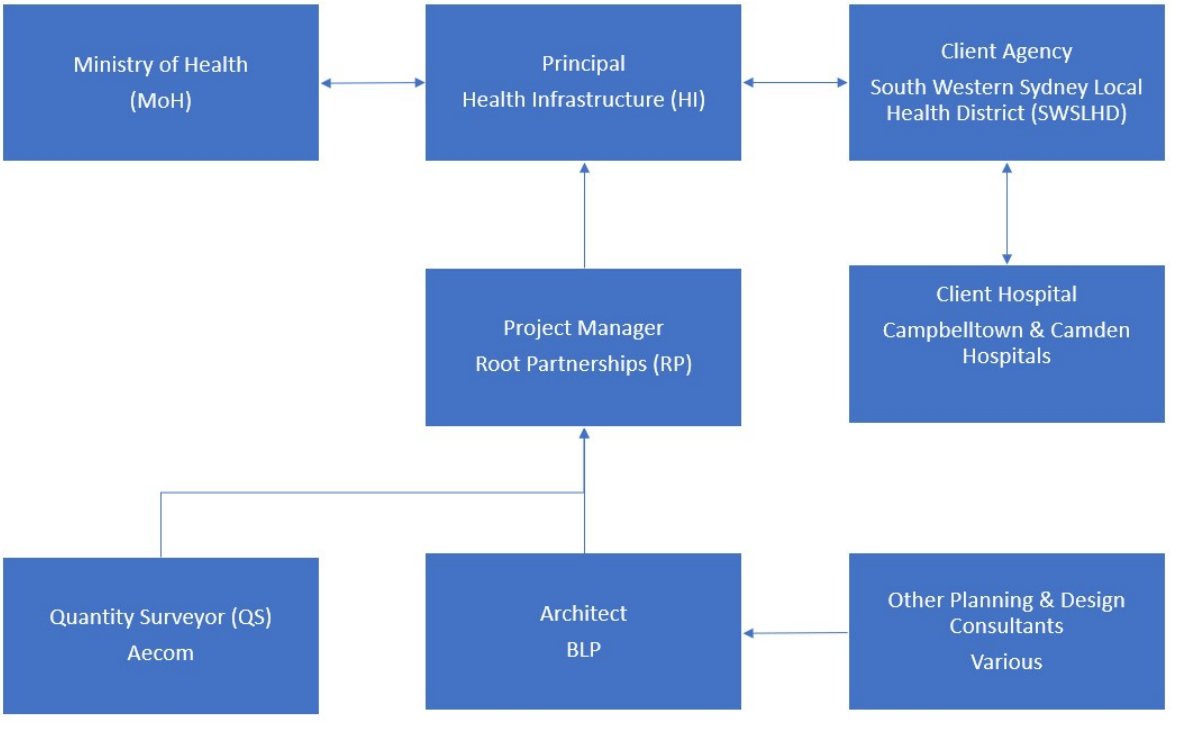
Meeting	Key Objectives	Frequency	Minutes by
Executive Steering Committee (ESC)	Overall Responsibility for delivery of the Programme	Monthly	Project Manager
Planning and Development Committee (PDC)	Manage all activities and report on the status	Monthly	Project Manager
Project Planning Team (PPT)	Planning and implementation for operations	Monthly	Redevelopment Team
Clinical Reference Group (CRG)	Expert clinical advice	Monthly, or less frequent as required	Project Manager
Clinical Reference Working Group (CRWG)	Expert clinical advice (subject matter specific)	As required	Project Manager
Project User Group Meetings	Intensive consultation to assist with determining user requirements	As required	Project Manager or Architect (subject to particular meeting)
Expert Reference Groups	Industry and subject matter expert review	As required	Project Manager
Project Management Meetings	To plan and review the project deliverables, resources and constraints	Weekly	Project Manager
Design Coordination Meetings	Design team to workshop design of the facilities	Weekly	Architect (BLP)

7. Project Team Structure

7.1 Project Team Structure

Project Organisational Structure is illustrated in the figure below.

Figure 7.1 – Project Team Structure



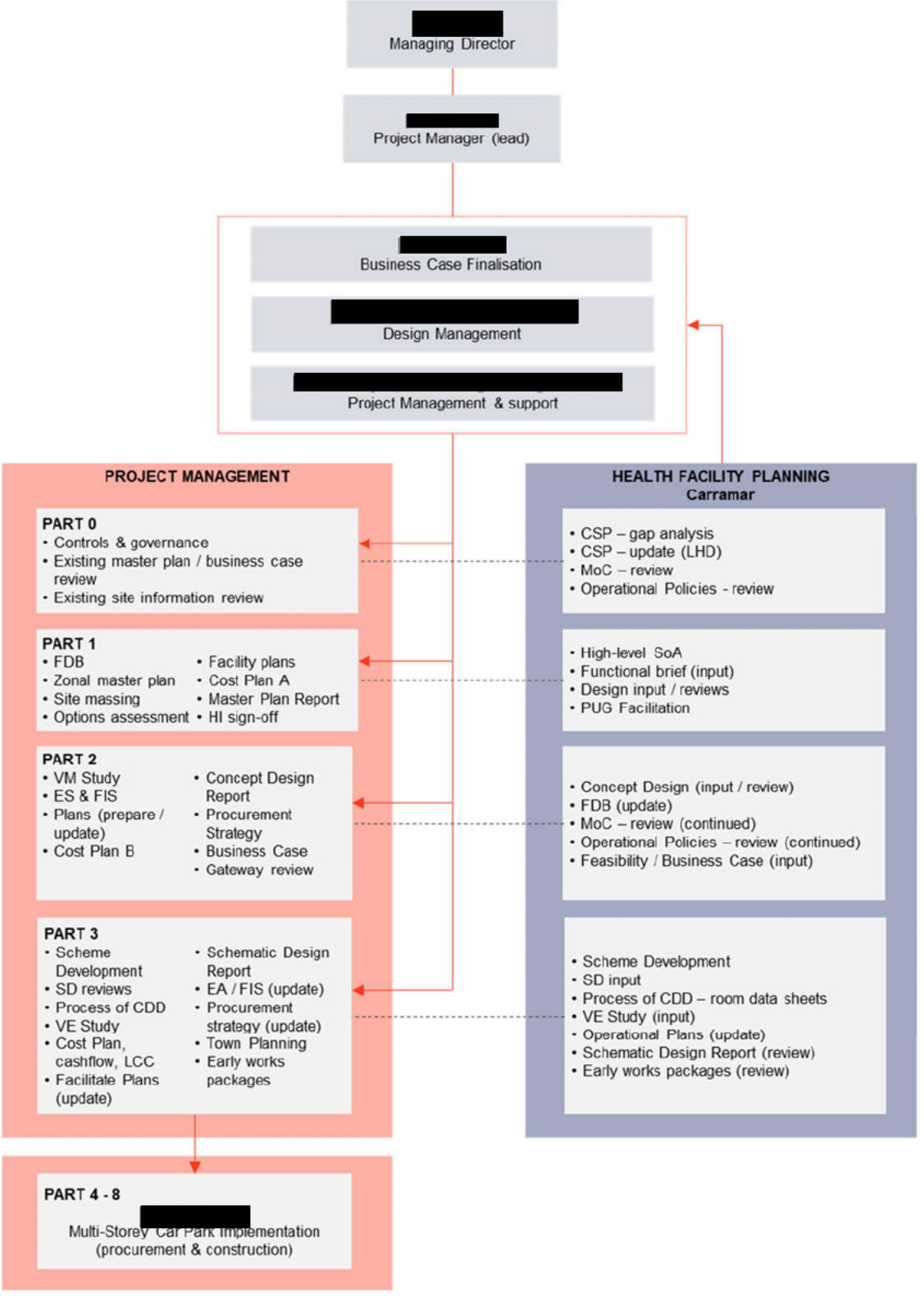
7.2 LHD Resources

A LHD Redevelopment Team will be setup at Campbelltown Hospital to oversee liaison and interface with the Hospital executives. The Redevelopment Team will be led by the Director of Redevelopment and will also have roles to manage communications, change management, workforce planning, and commissioning/operations activities.

7.3 Consultant Team Structure

RP has been engaged as the Project Manager for the project. To ensure the best outcomes for HI, RP has engaged the services of a Health Services Specialist – Carramar. The structure of the project is shown above and the roles and responsibilities listed in the table below.

As Project Manager RP will manage the procurement of all other consultants needed to complete the project, including planning, civil, structural and all building services. The engagement of these sub-consultants will be direct to HI whilst the procurement process will be managed by RP. The figure over the page links project activities with resources.


[redacted]
Managing Director
[redacted]
Project Manager (lead)
[redacted]
Business Case Finalisation
[redacted]
Design Management
[redacted]
Project Management & support
PROJECT MANAGEMENT
PART 0
• Controls & governance
• Existing master plan / business case review
• Existing site information review
PART 1
• FDB
• Zonal master plan
• Site massing
• Options assessment
• Facility plans
• Cost Plan A
• Master Plan Report
• HI sign-off
PART 2
• VM Study
• ES & FIS
• Plans (prepare / update)
• Cost Plan B
• Concept Design Report
• Procurement Strategy
• Business Case
• Gateway review
PART 3
• Scheme Development
• SD reviews
• Process of CDD
• VE Study
• Cost Plan, cashflow, LCC
• Facilitate Plans (update)
• Schematic Design Report
• EA / FIS (update)
• Procurement strategy (update)
• Town Planning
• Early works packages
PART 4 - 8
[redacted]
Multi-Storey Car Park Implementation (procurement & construction)
HEALTH FACILITY PLANNING
Carramar
• CSP – gap analysis
• CSP – update (LHD)
• MoC – review
• Operational Policies - review
• High-level SoA
• Functional brief (input)
• Design input / reviews
• PUG Facilitation
• Concept Design (input / review)
• FDB (update)
• MoC – review (continued)
• Operational Policies – review (continued)
• Feasibility / Business Case (input)
• Scheme Development
• SD input
• Process of CDD – room data sheets
• VE Study (input)
• Operational Plans (update)
• Schematic Design Report (review)
• Early works packages (review)

7.4 Roles and Responsibilities

The roles and responsibilities on the RP team are listed in the table below:

Project Management Team		
Position	**Name**	**Role**
Consultant Principal	[redacted]	• RP project principal • Facilitation and participation in key stakeholder consultation and presentation • Participation in key HI project governance meetings
Project Director	[redacted]	• Leadership of the RP team and active participation through Part 3- Schematic Design and the Multi-Store Car Park Implementation phase • Responsible for the successful delivery of the project through to June 2018
Senior Project Manager Business Case	[redacted]	• Leadership of the RP team and active participation through Parts 0-2 and the commencement of Part 3 and the Multi-Store Car Park Implementation phase. • Responsible for the successful delivery of the project through to March 2018 • Part 0 – Master Planning: - Site information - Design manager for development of zonal, block planning and floor-plates • Part 2 – Feasibility: - Options development & VMS / VES - Concept Design Report - Author of the final business case - Coordinate input of financial reports (QS, FIS, CBA) - Lead for Gateway presentation - RP lead at key HI project governance meetings - Design Management (refer below) - Risk management • Part 3 – Schematic Development - Commencement of Schematic Design
Senior Project Manager Design Management	[redacted] [redacted]	• Part 0 – Master Planning - Site information - Design manager for development of zonal, block planning and floor-plates • Part 2 – Feasibility, assist the business case author in the delivery of: - Options development & VMS / VES - Concept Design Report - Risk management - Coordinate input of financial reposts (QS, FIS, EA, etc.) • Part 3 – Schematic Development - Design manager for schematic design - SDR - Value engineering study - Town planning application - Continued business case support

Project Management Team		
Position	**Name**	**Role**
Project Manager (Project Support)	[redacted]	• Part 0 – Master Planning • Part 2 – Feasibility / Business Case • Part 3 – Schematic Development • Portal interface with HI • Consultation planning and support documentation • Reporting and program preparation
Project Manager Multi-Storey Car Park Implementation	[redacted]	• Procurement and construction of multi-storey car park. Expected completion in September 2019.
Health Facilities Planning (Carramar)	[redacted] (Project Director & Strategic Oversight) [redacted] (service planning advisor and review of current planning) [redacted] (quality review) [redacted] (review of documentation) [redacted] (review of documentation) [redacted] (FDB) [redacted] (FDB, SOA, project support) [redacted] (FDB, SOA, project support)	• Conduct the review and/or prepare: - CSP – gap analysis - Models of Care - SoA - Functional Brief (clinical input) - Operational policies - Change management strategies • Across the Parts of: - Project Initiation - Master Planning - Feasibility Development - Process of Clinical Design Development - Schematic Design Development

7.5 Communication Channels

Communications and consultation activities are required to ensure the Project is informed by engaged stakeholders in order that there is proactive management of expectations and mitigation of relevant risks. The communications and consultation management approach for the Project shall ensure strategic, transparent, professional and proactive strategies are developed and implemented.

The Project Manager will work with the Communications Manager, all stakeholders, Health Infrastructure, and the LHD to support the Project communications and consultation activities to promote a low risk environment during the implementation of the Project. The Communication & Engagement Plan can be viewed upon request.

The Redevelopment Team will develop a Communication & Engagement Plan for the project. The Project Manager will proactively manage, in conjunction with the Redevelopment Team, the engagement of stakeholders to ensure issues are quickly identified and addressed including disruptions to staff, patients and community and day to day operations.

8. Programme

8.1 Project Milestones and Timeframes

The milestone for completion of the Project phases are:

Project Program Summary		
Part	**Indicative Milestone**	**Date Completed or Date for Completion**
Part 0	Project Initiation	September 2017
Part 1	Master Planning	November 2017
Part 2	Concept Design / Feasibility Development	December 2017
Part 2	Business Case (draft)	December 2017
Part 2	INSW Gate 2 Review	February 2018
Part 2	Business Case submission to MoH	April 2018
Part 2	Business Case approved from MoH	May 2018
Part 3	Schematic Design Process	June 2018
Part 3	Early Works (Carpark) Construction - commenced	June 2018

8.2 Program Review

The program and progress toward achieving the key milestones will be monitored by the Project Manager and reviewed on a monthly basis. The status will be reported in the Project Manager's monthly report to the PCG.
Sub-programs and detailed programs will be developed with relevant stakeholders, consultants, contractors and FFE suppliers as necessary to develop an understanding of program and timetable requirements for particular situations, feeding these sub-programs into the master program to ensure effects and consequences are managed.

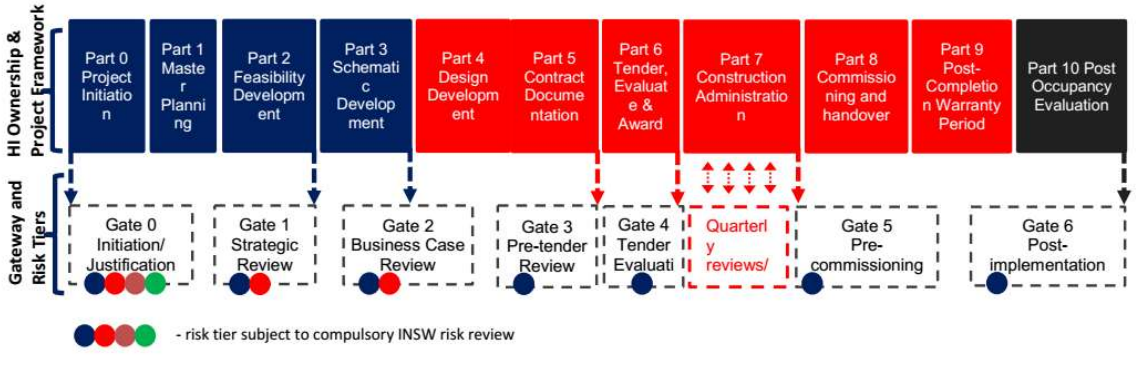
Extension of Time Procedures

The Project Manager will submit advice of extension of time requests to the client in the event of delays due to:

- Scope change or delay specifically requested by the client;
- Extended delays to the provision of planning permission outside of reasonable expectations (and as advised by the town planning consultant);
- Extended delays for the construction programme as a result of archaeological discoveries; and
- In the event that it is not possible to procure a contractor who will agree to meet the client's program.

8.3 Gateways

HI Projects are governed by the NSW Government Gateway Review Process, which has a number of gateways and reviews through which the Project must pass. The relationship of these milestones with the POFP Stages and the HI Delivery Standard Phases and Parts is shown in below:



8.4 Proposed Methodology

The Project Manager will lead the delivery of the project through the Phase 1 - Planning as indicatively outlined below. The project phases will run concurrently to achieve the milestone dates.

Part 0 – Project Initiation
A peer review of existing planning documents will be undertaken to ensure that they are correct, complete and appropriate in establishing the foundations of the capital investment and to inform the development of the built response. The intent is to deliver excellent health outcomes within the constraint of the capital budget and deliver effective operational models with efficient recurrent cost structures.

- Clinical Services Plan (gap analysis) – The Project Manager will (with Carramar) conduct a gap analysis of the Clinical Services Plan (CSP). The intent of the analysis is to ensure that the CSP aligns to the NSW State Health Plan; aligns to population needs and health service demands; appropriately considers coordinated and integrated health services and linkages with other healthcare centres and providers; makes use of current and future technology; and is the right response given the hospital's location.
- Models of Care (MOC) – The Project Manager will (with Carramar) review the MOC to ensure they are responsive to the communities which are being served. Guiding principles in the review will include being patient-centric and enable equity of access; support integrated care whilst allowing localized flexibility; enable efficient use of human resources and deliver quality care for patients; and capture innovation in work practices and technology whilst being future focussed. The MOC should be based on best practice evidence available, developed in consultation with clinician and health-carers, be cost affordable, and extend across the whole of the patients' healthcare journey.
- Existing Master Plan / Business Case (2014) – The Project Manager will review the existing documents to identify and test the appropriateness of the zonal planning proposed then to identify what could be brought forward to the master plan study.
- Review Stage 1 – Incorporate lessons learnt from the Stage 1 development review documentation (i.e. post occupancy evaluations), i.e. governance, communication, interaction in the planning process, adverse site impacts, etc.
- Existing Site Information – The Project Team will immediately progress with the collection, analysis and gap-identification of site information. This will include: existing building asset information (functionality, condition, size, etc.); building engineering assessments; site engineering infrastructure (condition, capacity, etc.); above ground / in-ground hazmat and site contamination; historical significance, etc. This will inform the development of master plan options.

Part 1 – Master Planning
Testing of existing master plan zones and functional relationships with existing clinical buildings and infrastructure will be conducted including:

- Schedule of Accommodation (SoA) – On appointment, the Project Manager will (with Carramar) commence the development of the high-level SoA in accordance with HI guidelines. It is key that these are reflective of, the CSP, MOC and operational strategies. The SoA must be an effective and efficient translation of the preceding services documents.
- Functional Design Brief (FDB) – The Project Manager will (with Carramar) prepare the FDB which will translate the preceding clinical and associated plans into a clear set of principles and metrics to inform the development of master plan design options.

- Master Plan – The development of an effective site master plan will involve the assessment of various options through a structured process. A process will be used to identify, analyse and assess developing options against key criteria and value management principles. The master plan will require planning through the user-group consultation process to inform the siting of buildings and the evolving concept designs. This will comprise:

  - Zonal master planning – to determine the efficient use of the whole of the site in the context of: its interaction at external boundaries; the orientation of buildings in response to solar and site topography; creating buildings with a sense of place and welcoming to the local community; and with future development opportunities not frustrated. Any specific neighbour or access issues will be identified and opportunities for interconnection with third-party providers.

  - Block planning – site use layouts showing the proposed location of key clinical services units (CSU), one to the other, clinical / non-clinical support and function relationships / pathways.

  - Floor plates – the layout of CSUs reflecting the particulars of the MOC and operational strategies. This level of planning enables the clinicians to gain a better understanding, and provide support, for how specific CSUs will operate.

- Cost Plan A – The Project Manager will collaborate with the Cost Planner for the development of a cost plan which accounts for the estimated total out-turn cost accounting for the gross floor areas, site conditions, engineering infrastructure, decant / staging costs, temporary works, project contingencies, etc.

The phase will conclude with the submission of a Master Plan Report subject of the project governance structure.

Part 2 – Feasibility Development
There will be a single business case which will be supported by concept design level documentation prepared in the master plan phase. The feasibility development will run in parallel with the production of the master plan.

- Financial – The finical aspects will be informed by a Value Management Study, the Economic Appraisal / FIS, and Cost Plan B. A substantive VMS will explore a range of options assessed against the key health objectives and outcomes for Campbelltown Hospital and the LHD. The Project Team will explore non-capital solutions in the delivery of clinical services to ensure that capital funding is optimally spent and to reduce the recurrent cost burden. A number of well-structured workshops will be used to consider and propose outcomes for options assessment, risk management and procurement strategy. These will be attended by key Project Team staff and located at Campbelltown.
- The production of the CBA / FIS will be assisted and informed by early engagement of a CBA / FIS specialist.
- Operational Strategy and Change Management Strategy – The Project Manager will (with Carramar) assist with the development of the Operational Strategy and related policies to translate the body of knowledge within the CSP and MOC into the recurrent day-to-day operational workings of the hospital. The strategy will address key matters including:

  - Building and hospital operational commissioning to ensure the health services are operationally ready from day one;

- Provide control, accountability and authority to the hospital and Health Service as early as possible in the operational commissioning process;

- Review governance framework and have governance structures to facilitate clinician input into patient safety and quality risks;

- Maximise the use of technology (with a view to optimising risk management) to support health care services;

- Establishing the workforce in advance of being operational including teaching and training for new MOC and technology, and attracting and retaining staff for long-term implementation;

- Establish contract arrangements with clinical and non-clinical services providers (internal / external; public / private); and

- Proactive engagement and thorough communication regarding the benefits and challenges in delivery of the health services set out in the CSP.

This phase will conclude with the production of the Concept Design Report which clearly states the design objectives and principles for the project.

Part 2 – INSW Gateway
The Project Manager will collaborate with the consultant team and lead the development of, and author, the Business Case and manage the Gateway review process. There are several key components which feed into and support a robust business case, including:

- Case for Change – demonstrate the need to position the project as a priory and support allocation of funding.
- Options assessment – use of quantitative and qualitative resources thorough value management studies with preferred option supported by the cost benefit analysis.
- Stakeholder support – use communication management processes with the involvement of all relevant internal and external stakeholders.
- Risk management – demonstrate that the project has full awareness of the challenges, with mitigation measures and appropriate contingencies, to gain Gateway review support.
- Implementation plan – A procurement strategy to facilitate early works commencement, staged construction whilst maintaining the operational effectives of the hospital.
- Governance approval – Lead the project through the INSW Gateway process.
- This phase will conclude with INSW issuing a final report with recommendations.

Part 2 – Business Case
The Project Manager will collaborate with the consultant team and lead the development of, and author, the final Business Case for submission to MoH to obtain MoH approval.

Part 3 – Schematic Development
The Project Team will deliver the schematic design. The town planning application and the early works / enabling works design.

- Schematic Design – This will be developed with user group input with structured peer reviews at set stages, i.e. 40%, 70% and 100%. The design development will include the process of clinical design development (CDD) to bring forward user-group contribution to

the development of room data sheets and room layout sheets for clinical related areas. This will leverage off the EUG supplemented with input by the Clinical Reference Group, and closed out with formal endorsement.
- Town planning application – Compliant with the statutory planning approval process and as informed by the Town planning consultant and the town planning strategy.
- Early works / Enabling Works – The phase will deliver the early works design packages for carpark, temporary structures, demolition, engineering infrastructure upgrades, temporary access routes, etc.
- Financial – The schematic design will be subject to Value Engineering Studies to obtain best value for money outcomes and ensure compliance with budget. The Cost Plan (cost, cash flows and life-cycle costs) will be reconfirmed.

This phase will conclude with the production of the Schematic Design Report (SDR) with all strategies and plans updated, financial matters and costs reconfirmed, procurement strategy restated.

9. Cost Planning, Management and Reporting

9.1 Cost Planning

The cost planning and management will be carried out by Aecom engaged directly to HI. The Project Manager will work collaboratively with the Cost Planner and design team to coordinate and the estimates and cost reports as the works progress, and at critical milestones and gateways.

All cost planning is to be carried out and reported in accordance with the Service Delivery Plan from the Quantity Surveyor, and in accordance with HI Cost planning and Reporting Standards, June 2015, V3.

The Cost Manager will be required to establish and maintain the Project Cost Plan.

9.2 Options Development and Value Management

The Project Manager will work in collaboration with the Cost Planner to provide develop options which can be priced by the Cost Planner and will also lead and participate in Value Management of the selected option.

9.3 Cost Reporting

The Cost Manager will:

- Establish and maintain cost planning services for all stages of Program development;
- Maintain quality control systems that ensure all information and documentation provided is complete, comprehensive, up to date, checked and coordinated
- Prepare financial analyses for the Program in accordance with professional best practice and with the Principal's requirements for benchmarking of projects
- Develop and update the Project Budget
- Provide proactive cost management advice to the Project Team with regular updated estimates of project cost based on design and construction documentation. This will

include preparation of design cost reports that provide the design team materials lists and elemental cost reviews of design elements that are influencing cost.

- Provide cash flows for the Project
- Provide proactive cost management advice with progressive statements of costs against the anticipated final cost of the Project
- Prepare detailed financial analyses indicating capital and recurrent costs of proposed building and services systems
- Measure work complete, prepare, process and make recommendations concerning payment of all accounts on the Project
- Measure, value and negotiate the cost of claims to the contract, construction variations or extensions of time and advise the Principal and Project Manager
- Advise the Project Team on the status of contingency
- Advise the Project Team of costs associated with, design decisions, a change of scope or client initiated requirements
- Prepare a detailed analysis of life cycle costs and recurrent operating costs of the Project as built in accordance with AS/NZ Standard 4536:1999 Life Cycle Costing—An Application Guide. The prepared material should be sufficient to enable the operator to determine an operational budget, maintain an asset register, depreciation of the assets and replacement costs for insurance purposes
- Provide real cost data and budgets for items in the design process
- Reconcile at regular intervals with the Principal and Project Manager total Project expenditure and commitments against the funding cost centres and prepare a report noting any inconsistencies, risks or areas of concern
- Provide cost estimates against the Project FF&E, MM&E, services, and ICT budgets
- Provide all Cost Plans and Reports in accordance with the HI Cost Planning and Reporting Standards, June 2015, V3.

10. Deliverables

10.1 Deliverables Summary

HI Part	Deliverables
Part 0 – Project Initiation	Project Management Plan
	LHD Resource Plan
	Governance Arrangements
	BIM Brief
	Consultant Procurement Strategy
Part 1- Masterplan	Services Statement
	Master Plan Report
	Cost Plan A (Masterplan)
Part 2 – Feasibility	Risk Management Plan
	Communication and Consultation Plan
	Change Management Plan
	Workforce Plan
	Functional Design Briefs
	Financial Impact Statement (prelim)
	Aboriginal Health Impact Statement

HI Part	Deliverables
	FF&E/ICT Strategy
	Economic Appraisal
	Value Engineering Workshop
	Concept Design Report
	Cost Plan B
	Benefits Realisation Plan
	Strategic Business Case
Part 3 – Schematic	Cost Plan C1
	FIS (Final)
	Schematic Design Report
	Final Business Case

11. Project Reporting and Information Management

11.1 Monthly Reporting

Monthly reporting is required for the Executive Steering Committee and the Planning and Development Committee. These reports will include sections covering:

- Progress and Program
- Issues & Risks
- Budget and Cost Management (included from the QS report)
- Change management

The following reports are to be produced throughout the duration of the Project.

Report	Recipient (Key Messages)	Method	Frequency	Issued by
Executive Steering Committee (ESC) Report	ESC	On HI Template. Via email / HI Portal and presented at ESC meeting.	Monthly	Project Manager
Planning and Development Committee (PDC) Report	PDC	On HI Template. Via email / HI Portal and presented at ESC meeting.	Monthly	Project Manager
Cost Planning Report	ESC	On HI Template. Via email / HI Portal and presented at ESC meeting.	Monthly	Cost Planner

11.2 Records Management

For the purposes of Records Management, all Deliverables as defined in the Project Manager's Contract are considered to be the Project Records.

To aid Health Infrastructure in meeting its obligations under the State Records Act (NSW) 1998, the Project Manager will ensure that the following record keeping requirements are satisfied in its delivery of the Services:

- Maintain a record keeping system that stores all Project Records related to the Services provided by the Project Manager, and maintains appropriate version control in accordance with Standards issued under the State Records Act (NSW) 1998;
- Consultants must ensure the security of Project Records created and maintained for the Services in accordance with Standards issued under the State Records Act (NSW) 1998 and the NSW Government Digital Information Security Policy of November 2012.
- Provide all Deliverables to Health Infrastructure for storage in accordance with State Records Act (NSW) 1998;
- Must only dispose of Project Records in accordance with specific instructions specified by the Health Infrastructure;
- Upon completion, expiry or termination of the contract, the Project Manager will transfer all Project Records created and maintained for the Services in a format and manner which allows the Project Records to be quickly and easily retrieved, reviewed and utilised by Health Infrastructure. This includes maintaining any relationships between the Project Record object and any control tools needed to interpret and understand the object.

11.3 Health Infrastructure Portal

The HI Portal is used as a singular reference point for all Project information. Each project has a profile within the HI Portal which must be constantly accessed and updated throughout the Project life-cycle to maintain correct and current project related information. The Health Infrastructure will provide the access to the HI Portal on the commencement of engagement.

The Project Manager and other consultants will use the HI Portal, in accordance with relevant HI SPPG or as otherwise necessary to ensure successful completion and documentation of the Project. This includes the accessing of documents, relevant data input and processing, and the upload and amendment of completed Deliverables. Governance Reports and Key Deliverables are to be saved to the HI Portal at completion of each part.

Health Infrastructure is responsible for the provision of the HI Portal. All system or performance issues or comments should be forwarded to Health Infrastructure. Health Infrastructure will provide training to the Consultants on the use of the HI Portal upon request

11.4 Aconex

Aconex will be used as the Project communication and file transfer platform.

12. Design Management

The management of the design process is a key tool in achieving the desired project outcomes. A structured work plan for the project design team provides clarity, and ensures consistent and coordinated documentation and reporting.

Key inputs for design management for the Campbelltown Hospital Redevelopment include:

- Dedicated team leaders
- Design Management Plan
- Management of the design program
- Design team input coordination
- Management of design reporting

12.1 Coordination and Integration

The Architect and design team will work hand in hand with the Project Manager to ensure consultant design input is managed in a timely manner.

Regular fortnightly design coordination meetings will be supplemented with Design and Technical workshops with specific consultants as required to quickly identify and workshop areas of scope that need to be addressed and resolved. Action items will be addressed and tracked via an agenda, and project information will be issued to the team regularly for information. The Architect will oversee and coordinate consultant input and ensure deadlines are being met.

The integrated tools created, managed and used by the Architect for the management of the design are as follows:

- Project Management Plan which details all parties, all meetings, terms of reference, etc structured in a clear articulate way.
- Detailed Project Programming integrated into the BIM model and into the contractors' delivery schedule
- Risk Management and Safety in Design Workshops to ensure timely mitigation of potential risks to the project including a design Risk Register
- A Design Change Register to record requests for changes and ensure clear instructions before proceeding
- Project Benchmarking and Operational Testing scenarios to assess likely operational and recurrent cost implications
- User Group Toolkits to ensure a timely and effective buy-in by these stakeholders
- Building Materials Databases and Workshops testing whole of life criteria
- Quality Management documents including project checklists and proforma to safeguard the highest levels of quality in service delivery and architectural designs

12.2 Building Information Management (BIM)

All Health Infrastructure Projects are to be delivered within a BIM environment, in accordance with the Building Information Management – Requirements for Projects (including data management requirements, November 2016, V2.2. Part of the Architects scope is to deliver a design BIM Management Plan based on the requirements defined in the Project BIM Brief.

The design team will design and document the project using Building Information Modelling (BIM).

The Architect will use industry-standard BIM tools such as Autodesk Revit for design and documentation, dRofus for space planning & FFE management, and Aconex file sharing platform for communication and coordination. This work flow and tools will also extend to the sub-consultants and contractors.

12.3 Value Engineering

A process of Value Engineering will be undertaken to ensure that the project objectives meet within the budget allowed. This will be a collaborative process with key stakeholders to ensure the best project outcomes.

12.4 Design Certification

As a key component in the Design Team Quality Management System, led by the Architect, each of the design team disciplines will provide their design drawings and reports along with certificates.

13. Change Management

Change Management is the process of re-aligning an organisation to meet the changing demands of its environment and is generally underpinned by improvements to its processes, technologies and service outcomes. It encompasses the management of change impacting and influencing culture, service processes, physical environment, job responsibilities, staff skills/ knowledge and policies/ procedures.

It is imperative that change has a positive impact on the day to day lives of the staff, management and users of the hospital over the longer-term operation of the new facility and any transitional uncertainties are managed.

The key objectives of the change management strategy are to:

- Utilise the guiding principles outlined in the Change Management Methodology to address all change items arising as a result of the redevelopment.
- Establish Change Management governance and protocols.
- Establish a Change Register to identify change items, assess the extent and significance of the change, and identify a change owner and strategy to manage the change item.
- Undertake a Change Management risk analysis for each stage of the project to inform the Risk Management Plan and Risk Register.
- Monitor, evaluate and report on each of the change items.
- Utilise the Consultation and Communication Plan to ensure that key changes arising are communicated to stakeholders
- Ensure that adequate resources are allocated to manage the change process (through an appropriate allocation within the project budget)

The Redevelopment Team will develop the Change Management Plan (CMP) for the Project in accordance with the HI SPPG and HI Templates.

14. WHS and Environmental Plan

14.1 Work Health Safety System

The Project Team will comply with all relevant Statutory Requirements and Standards, e.g. the Work Health and Safety Act (NSW), 2011 the Work Health and Safety Regulation (NSW) 2017, and the NSW Government Work Health & Safety Management Systems and Auditing Guidelines (or any legislation amending or superseding these acts).

The Project Team will comply with all requirements of, or directions given by, any Principal Contractor (as that term is defined in clause 293 of the Work Health & Safety Regulation 2017), or the person with management or control of the site, with respect to work, health and safety issues at the site, including entering any arrangement or agreement with the Principal Contractor or that person.

The Project TEam will ensure that the Architect and other consultants incorporate the principles of safe design for work from the Australian Safety and Compensation Council's (ASCC) Guidance into the design process. As part of the Project Team, the Project Manager will coordinate with the LHD's WHS team to conduct the necessary risk assessments and facilitate the provision of relevant supporting advice.

14.2 Consultant WHS for site inspection and investigations

When works are being carried out on site, the Principal and Contractor must provide the Project Manager with information about the following:

- The adequacy and safety of any site office accommodation to be used accessed or used by the Project Team
- The adequacy of Personal Protective Equipment (PPE) issued to on-site Project Team members
- Procedures for ensuring the adequacy of facilities for the welfare of the Project Team members who are located in a site office, including that Project Team members receive the physical resources and amenities (IT; stationery; office furniture; etc) they require in order to carry out project tasks.
- Details of the Principal's and the Contractor's procedures, policies and induction and other training for work health and safety (WH&S)
- Any required site passes or security clearances for the Project Team members together with a written description of the obligations that go with the provision of the site pass.
- That adequate information is provided confirming that work at the site is being conducted in accordance with all applicable laws and established best practice guidelines.

Project Team members will not go on site until they have attended the Principal's and/or the Contractor's site WH&S induction course and have been provided with the relevant PPE.

The Project Manager does not accept any WH&S management responsibility for the Principal's, the Contractor's or a Subcontractor's site. The WH&S responsibility rests solely on the Principal, Contractor or subcontractor (as the case may be) and includes the obligation to:

- Ensure that the areas it controls within the site are safe and without risks to health to Project Team members;
- Ensure that plant or substances used by Project Team members are safe and without risks to health when properly used

- Ensure that its systems of work and the working environment of Project Team members are safe and without risks to health;
- Provide training to Project Team members to ensure health and safety at work;
- Provide adequate facilities for the welfare of Project Team members at the site;
- Ensure that work at the site is being conducted in accordance with all applicable laws and established best practice guidelines.

14.3 Safety in Design

The Architect is responsible for ensuring, Safety in Design principals are an integral part of the design process. This will be informed by experience and managed through workshops and a Design Risk Register.

14.4 Environmentally Sustainable Development & Environmental Management Plan

In the early stages of the planning and design an Environmental Management Plan will not be required.

The Project Manager will coordinate the design team to ensure the project is designed to targets as outlined in relevant HI SPPG. These include targeting a 4 Star Green Star rating assessment and achieving a 10% improvement on NCC (formerly BCA) Section J requirements and providing value management opportunities and modelling proof for any recommendations made. ESD issues will be considered and addressed, early in the Project, as well as throughout the Project.

When required for the Project and or the early works carpark an EMP will be the responsibility of, and prepared by, the contractor carrying out the works.

15. Quality Management

15.1 Quality Management Process

The Project Manager and Architect are to maintain a third party accredited system for its Quality, Environmental and Occupational Health & Safety Management Systems, developed to the requirements of the relevant ISO standards.

15.2 Consultant Performance Reports (CPRs)

HI Project Management tools include set procedures and templates to periodically review the performance of the consultant team. The Project Team will cooperate with Health Infrastructure as and when these performance reviews are required.

16. Risk Management

16.1 Risk Management Process

Health Infrastructure has developed a project risk management procedure PRC 102 January 2010. This procedure complies with the Australian Standard AS/NZS 4360:2004 and PD2009_039: Risk Management – Enterprise Wide Policy and Framework – NSW Health.

This Risk Management procedure is shown in Figure 16.1.1, and will be used for the project and is described below as follows:

Establishing the Context
The context within which the activity will take place has been clearly defined with this Project Management Plan. In particular the Project Structure, Project Reporting and Project Roles and Responsibilities outline the environment for managing risk.

Risk Identification
Initial risks were identified during the first risk management workshop and will be updated throughout the Project.

Risk Analysis, Risk Evaluation, Communication and Consultation and Monitoring and Review
The activities of Risk Analysis, Risk Evaluation, Communication and Consultation and Monitoring and Review will be a circular process aimed at minimising exposure to risk at all stages of the Program. The PDC is the group identified as responsible for managing risk on the Program.

Each identified risk is required to be assessed as to the potential impact. The likelihood and consequence ratings used to assist with this activity and shown in Figure 16.1.2.

Figure 16.1.1: NSW Health Risk Management Framework

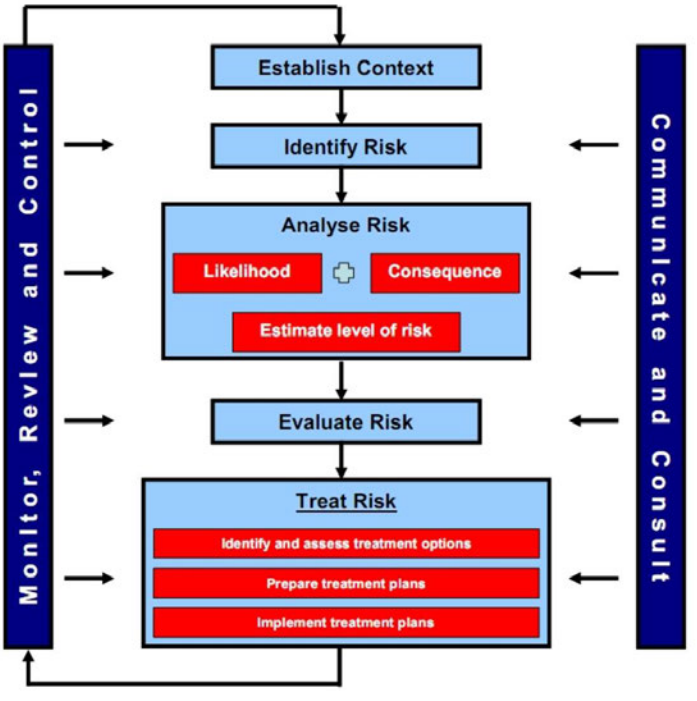


Figure 16.1.2: Enterprise-Wide Risk Management Framework

Enterprise-Wide Risk Management Framework

NSW GOVERNMENT Health FRAMEWORK

NSW Health Risk Matrix

Risk rating	Action required
Red = Extreme (A – E)	**Escalate to CE or Head of Health service or Secretary, MoH** A detailed action plan must be implemented to reduce risk rating with at least monthly monitoring and reporting.
Orange = High (F – K)	**Escalate to Senior Management** A detailed action plan must be implemented to reduce risk rating.
Yellow = Medium (L – T)	**Specify Management Accountability and Responsibility** Monitor trends and put in place improvement plans.
Green = Low (U – Y)	**Manage by routine procedures** Monitor trends.

NSW HEALTH RISK CATEGORIES	CONSEQUENCE EXAMPLES				
	Catastrophic	Major	Moderate	Minor	Minimal
Clinical Care & Patient Safety	Unexpected multiple patient deaths unrelated to the natural course of the illness.	Unexpected patient death or permanent loss/reduction of bodily function unrelated to the natural course of the illness.	Unexpected temporary reduction of patient's bodily function unrelated to the natural course of the illness which differs from the expected outcome.	Patient's care level has increased unrelated to the natural course of the illness.	First Aid provided to patient unrelated to the natural course of the illness.
Health of the Population	An increase in the prevalence of known conditions contributing to chronic diseases across the state-wide population health KPI categories currently measured by NSW Health and or an increase of more than 10% in one or more category.	Failure to materially reduce the prevalence of known conditions contributing to chronic disease across the majority of the state-wide population health KPI categories measured by NSW Health and or an increase of more than 5% up to 10% in one or more category.	Failure to materially reduce the prevalence of more than one of the known conditions contributing to chronic disease from the state-wide population KPI categories measured by NSW Health and or an increase of more than 2% and up to 5% in one or more category.	Failure to reduce the prevalence of one of the known conditions contributing to chronic disease from the state-wide population health KPI categories measured by NSW Health or an increase of up to 2% in one or more category.	A preventative Health program has not demonstrably met planned objectives but the prevalence of known condition is continuing to decrease in line with KPI targets.
Workforce	Unplanned cessation of a critical state-wide program or service or multiple programs and services.	Unplanned cessation of a service or program availability within a Service Area with possible flow on to other locations.	Unplanned restrictions to services and programs in multiple locations or a whole hospital or community service.	Unplanned service delivery or program delays localised to department or community service.	Minimal effect on service delivery.
Communication & Information Facilities & Assets Security	Cessation of services due to loss, damage or unauthorised access to property, assets, records and information.	Prolonged service disruption or suspension of services due to the loss, damage or unauthorised access to property, assets, records and information.	Temporary suspension of services due to the loss, damage or unauthorised access to property, assets, records and information.	Localised disruption to services. Minor loss, damage or unauthorised access to property, assets, records and information.	Minimal effect on services. No loss or damage to property, assets, records or information.
Emergency Management	State-wide system dysfunction resulting in total shutdown of service delivery or operations.	Services compromised as service providers are unable to provide effective support and other areas of NSW Health are known to be affected.	Disruption of a number of services within a location with possible flow on to other locations in the area.	Some disruption within a location but manageable by altering operational routine.	No interruption to services.
Legal	Legal judgement, claim, non compliance with legislation resulting in indeterminate or prolonged suspension of service delivery.	Legal judgement, claim, non compliance with legislation resulting in medium term suspension of service delivery.	Legal judgement, claim, non-compliance with legislation resulting in medium term but temporary suspension to services.	Legal judgement, claim, non-compliance with legislation resulting in short term disruption to services.	Legal judgement, claim or legislative change but no impact on service delivery.
Finance	More than 5% over budget NOT recoverable within the current or following financial year. Unable to pay staff or finance critical services.	Up to 5% over budget or a material overrun NOT recoverable within the current financial year. Unable to pay creditors within MOH benchmark.	Up to 5% over budget but recoverable within current financial year.	Up to 1% temporarily over budget and recoverable within current financial year	Less than 1% over budget. Temporary loss of or unplanned expenditure related to individual program or project but no net impact on budget.
Work Health & Safety	Multiple deaths or life threatening injuries or illness to non-patients.	Death or life threatening injury or illness causing hospitalisation of non-patients.	Serious harm, injury or illness causing hospitalisation or multiple medical treatment cases for non-patients.	Minor harm, injury or illness to a non-patient where treatment or First Aid is required.	Harm, injury or illness not requiring immediate medical treatment.
Environmental	Permanent effect on the environment or is unlikely to recover.	**Long term effect on the environment. The environment will only recover through external assistance / intervention (EPA)**	Short term effect on the environment. Environment likely to make a full recovery through local planning and response measures.	Minor effect on the environment. Environment to make a full recovery by routine procedures	No lasting effect on the environment.
Leadership and Management	Failure to meet critical priority KPI's included in the service's performance agreement. Sustained adverse national publicity. Significant loss of public confidence, loss of reputation and/or media interest across NSW in services.	Failure to meet a significant number of priority KPI's included in the service's performance agreement. Sustained adverse publicity at a state-wide level leading to the requirement for external intervention. Systemic and sustained loss of public support/opinion across a service.	Failure to meet a number of priority KPI's included in the services' performance agreement. Increasing and broadening adverse publicity at a local level, loss of consumer confidence, escalating patient/consumer complaints. Extended loss of public support/opinion for a Facility/Service.	Failure to meet one or more of the KPI's (excluding priority KPI's) included in the service's performance agreement. Periodic loss of public support.	Minimal impact on local operations, local management review and occasional adverse local publicity.
Community Expectations					

Probability	Frequency
> 95% to 100%	Several times a week
> 70% to 95 %	Monthly or several times a year
> 30% to 70%	Once every 1 -2 years
> 5% to 30%	Once every 2 – 5 years
< 5%	Greater than once every 5 years

LIKELIHOOD	CONSEQUENCE RATINGS				
	Catastrophic	Major	Moderate	Minor	Minimal
Almost certain	A	D	J	P	S
Likely	B	E	K	Q	T
Possible	C	H	M	R	W
Unlikely	F	I	N	U	X
Rare	G	L	O	V	Y

16.2 Key Risks to Successful Delivery of the Project

Existing reports commissioned by HI have identified and reviewed Project Risks through workshops with relevant stakeholders. This report is titled – Campbelltown Hospital Stage 2 – Risk Workshop Report and Risk Management Plan (dated October 2014).

The following Key Risks require careful monitoring and control to achieve the successful delivery of the project:

- Forward looking staging and development methodologies to manage the continuity of the hospital service performance benchmarks through the Stage 2 redevelopment (i.e. bed capacity / numbers, ETP, NEST, infection, safety, quality and experience, etc).
- How best to complement the completed Stage 1 works especially the capital investment already delivered for the expanded emergency department and paediatrics outpatient services.
- How to overlay the enhanced service needs of the Stage 2 redevelopment. A timely review and reconfirmation of services zones will be undertaken, whilst recognising the topography of the site (vertical and horizontal transport links) and the need to not frustrate future redevelopment stages.
- Other challenges include: the continuation of stakeholder support by active communication; investigation of hazardous materials; identification of early works opportunities; and mitigating delivery and operational risks with quarantine of project contingencies.

16.3 Risk Management Plan

The following methodology will occur throughout the planning and implementation stage of the project.

- Establish a risk-aware culture for ongoing risk management of the Project;
- Distribute the risk register (and regular updates) to all Project Team members;
- Establish a “no blame” environment where any Project Team member can raise a risk-related issue, whether it relates to their own or any other organisation associated with the projects;
- Establish a standing risk agenda item for weekly project meetings;
- Allocate responsibility for individual risk treatment/mitigation actions to the project team members best able to undertake them;
- Undertake the treatment actions contained in the risk register;
- Identify new or emerging risks as they arise and decide whether they are of sufficient magnitude to warrant treatment. If so, add them to the risk register, determine the most appropriate treatment/s, and allocate implementation action/s and timeframe/s;
- Identify risk events that have appeared imminent and interventions taken to prevent their occurrence;
- Identify risk events that have occurred and action taken in response;
- Review risks on a regular basis and identify any that no longer pose a threat to the achievement of project objectives and can be removed from the risk register;
- Review the risk register every three months to ensure that the treatment plan, strategies and management system remain valid and relevant over time.

ONGOING IMPLEMENTATION OF THE RISK MANAGEMENT PLAN

Ongoing risk assessments will be undertaken in accordance with Health Infrastructure's Project Risk Guidelines (v1.0). Implementation will be managed by the project team based within the existing governance structure.

Committee	Risk Reporting
Planning and Development Committee	• significant current risks • copy of risk register • risks for decision or referral to ESC
Executive Steering Committee	• exception basis • material risks • risks impacting on project outcomes (time/cost/quality)

Risk management activities will be maintained as a standing agenda item at PDC and ESC meetings to ensure that:

- The risk register will be updated to:
  - reflect the status of risk treatments
  - include new risks identified during the period
  - include proposed or implemented controls
  - allocate responsibilities for implementing risk management actions
  - include risk events that have occurred and actions taken in response
  - remove risks previously identified that no longer pose a threat to the project

MONITORING, REVIEW AND REPORTING

Monitoring

The Project Manager will maintain regular surveillance of the preconditions (triggers) for:

- The occurrence of risk events;
- Any circumstances suggesting the need to re-evaluate risk impacts and initiate new risk treatments.

Reporting

Monthly reports will include a section on risk management addressing the following issues:

- Status of actions required to treat high ranked risks
- Any project risk-related correspondence or discussions, and their status and outcomes
- Reference to the current project risk register
- Assurance activities, status/progress and outcomes
- Monitoring activities and results.

Additional reporting may include:

- Outstanding risk treatments – by date or by risk owner
- High ranked risks under each risk category – per project and across the program

- Highest ranked risks overall
- Progressive impact of risk treatments (leading to reduced risk rankings) through the course of the project.

RISK MANAGEMENT PLAN AWARENESS AND REVIEW

This plan will be distributed to all members of the Project Team.

The project risk management plan will be reviewed annually to ensure that the plan, the nominated risk treatments and the risk register are current and remain valid and relevant over time.

Resulting actions may include:

- Changed risk roles, responsibilities or activities
- Changes to risk ratings
- Removal of elements that are no longer relevant
- Addition of new elements and associated controls e.g. new or emergent issues require inclusion in the plan
- Change in the responses applied to individual elements.

17. Consultant Procurement and Administration

All consultant engagements will be direct with HI. The Project Manager will develop and maintain a Procurement Strategy, then with HI approval, manage the procurement process for each of the consultants on behalf of HI including tender documentation, tendering, and tender assessment and recommendation. The Architect/Project Manager will then manage each consultant to achieve the deliverables and desired outcomes for the project. Each consultant package will be procured in accordance with the HI PRC600 Tender Procedures, May 2017 V2.

17.1 Disciplines to be Procured for the Stage 2 and the Carpark

The status of consultant procurement is included in Appendix 4.

17.2 Consultant invoicing and recommendation process

As each consultant engagement is direct with HI, each consultant will issue its invoice to HI for assessment and payment. Invoices should be submitted in accordance with the conditions set out in the RFT Section 5 Conditions of Agreement, Clause 6.

The timing of invoicing and payments shall in in accordance with the RFT Section 5 Conditions of Agreement, Clause 6.

HI may at any time request Variations from consultants. Variation requests and submissions must be made in accordance with the RFT Section 5 Conditions of Agreement, Clause 7.

18. Appendices

18.1 App 01 - Services Delivery Plan – Architect

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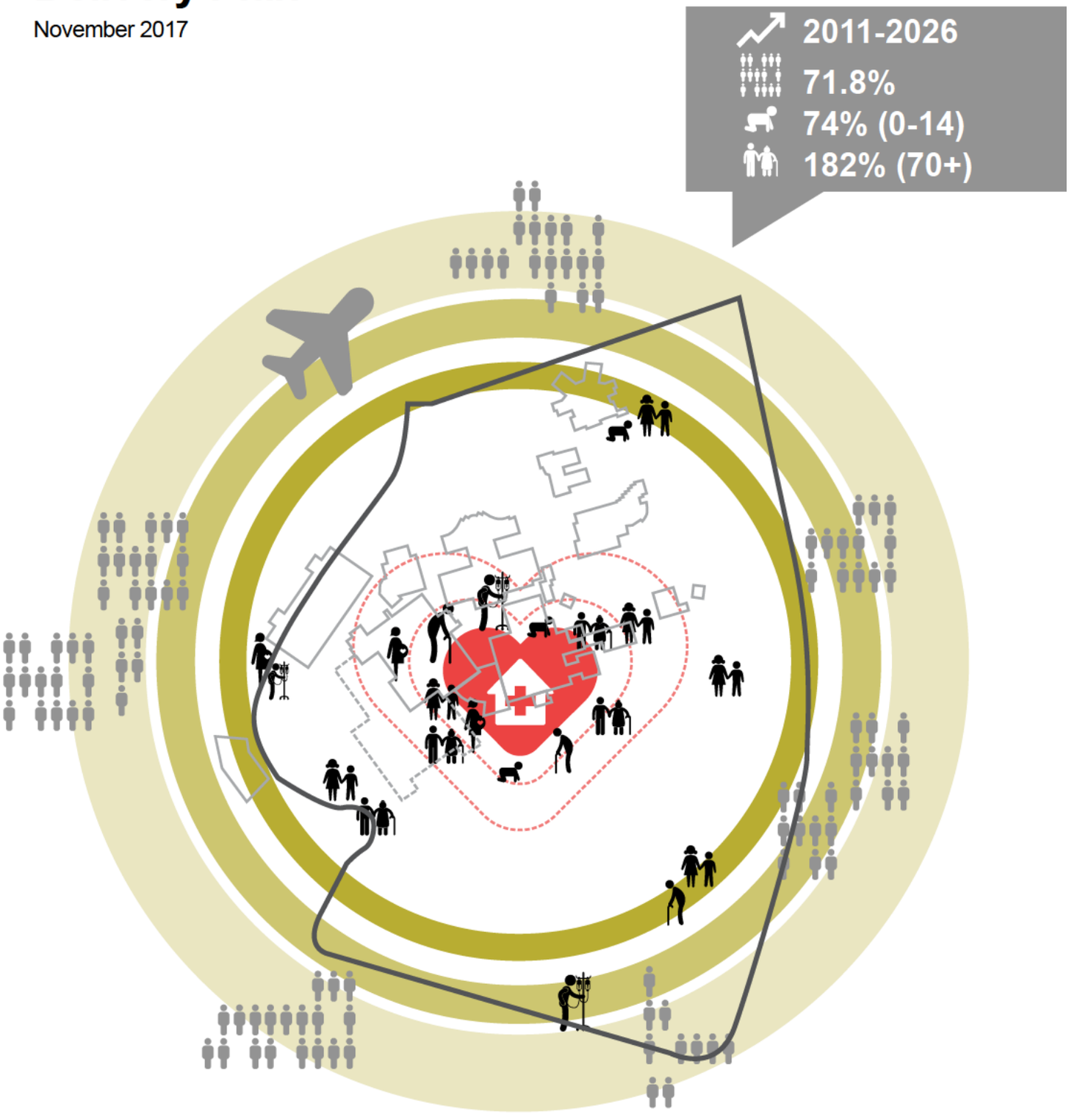
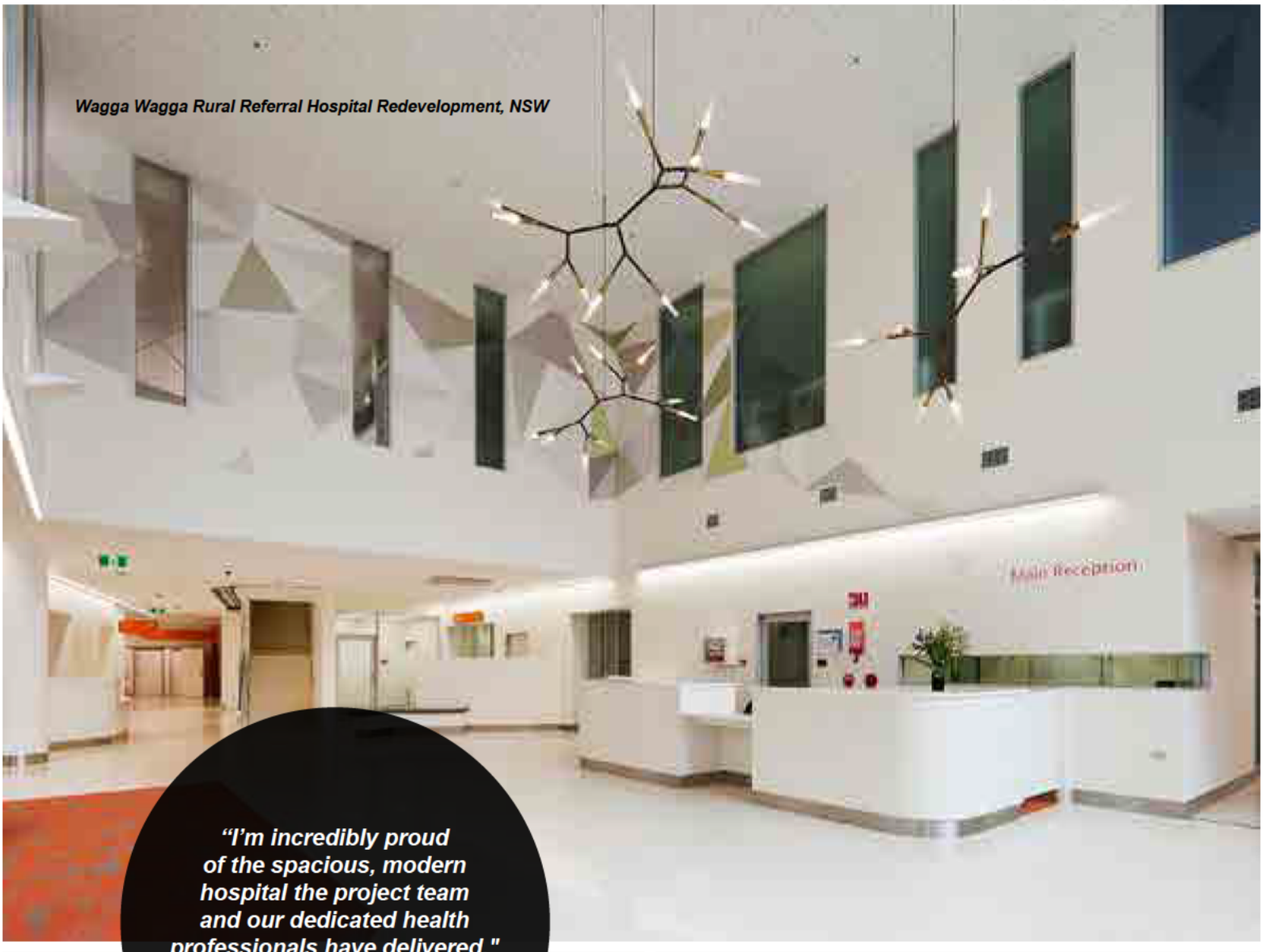
DRAFT

RFT HI17336

Campbelltown Hospital Redevelopment Services Delivery Plan

November 2017





Wagga Wagga Rural Referral Hospital Redevelopment, NSW

"I'm incredibly proud of the spacious, modern hospital the project team and our dedicated health professionals have delivered."

– Health Minister Jillian Skinner, Wagga Wagga Rural Referral Hospital

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Royal Children's Hospital Melbourne, VIC

"The Royal Children's Hospital makes a breathtaking contribution to Melbourne's civic realm, to its health and research aspirations and to its innovative and progressive architectural traditions."

- Australian Institute of Architects Jury Winner, AIA Victorian Architecture Medal 2012

1.0
Introduction

1.0 Understanding of the Project Scope

The redevelopment of Campbelltown Hospital will enable provision of healthcare to the Campbelltown Macarthur community until 2031 and beyond, encompassing integrated services across adult, paediatric and mental health streams.

The redevelopment is driven by significant population growth expected in Western Sydney, supported by plans for the new airport at Badgerys Creek, and the concept of the Western City as Sydney's third major hub, through the Greater Sydney Commission and the ambition of Campbelltown Macarthur to support health and education facilities as a driver for a sustainable city.

Project Scope

The redevelopment will provide major enhancements to the emergency department, additional operating theatres, and expansion of the intensive care unit, additional renal dialysis facilities, and expanded mental health facilities as well as expansion and enhancement of paediatric services.

The project will include:

- Additional mental health beds and services
- Reconfiguration and expansion of the Emergency Department (ED)
- Additional operating theatres
- Expansion of the intensive care unit
- Additional medical and surgical inpatient beds
- Expansion of outpatient services
- Expansion of the medical imaging capability
- Expansion of paediatric inpatient and ambulatory care services
- Improvements to supporting services and infrastructure

Royal Children's Hospital Melbourne, VIC

This redevelopment will support contemporary health services delivery, complement buildings already delivered in previous stages, and deliver a functionally consolidated and fit-for-purpose facility bringing together accommodation for a range of integrated health services. The project will increase access to healthcare across the care spectrum, from community health through to tertiary capacity.

The detailed planning phase will investigate how this scope will be delivered within the available budget to meet project objectives. This will include alignment with the endorsed site Master Plan and the LHD's updated clinical services planning based on the revised population projections.

Key Objectives

Key considerations for the Campbelltown Hospital Redevelopment Stage 2 will be to;

- Support implementation of agreed Better Health Value targets.
- Improve self-sufficiency in the provision of acute medical and surgical care for residents of the Catchment area.
- Improve service access and patient flow.
- Reconfigure and expand Emergency Department services.
- Improve access to outpatient services.
- Enhanced mental health facilities
- Increase surgical capacity.
- Increase inpatient bed base.
- Increase paediatric service self sufficiency at Campbelltown.

Services

The services to be provided include Parts 1 to 3 being;

Part 1 Master Planning Development of a revised Masterplan incorporating the LHD's priorities in accordance with the revised Clinical Services Plan (CSP) and car parking.

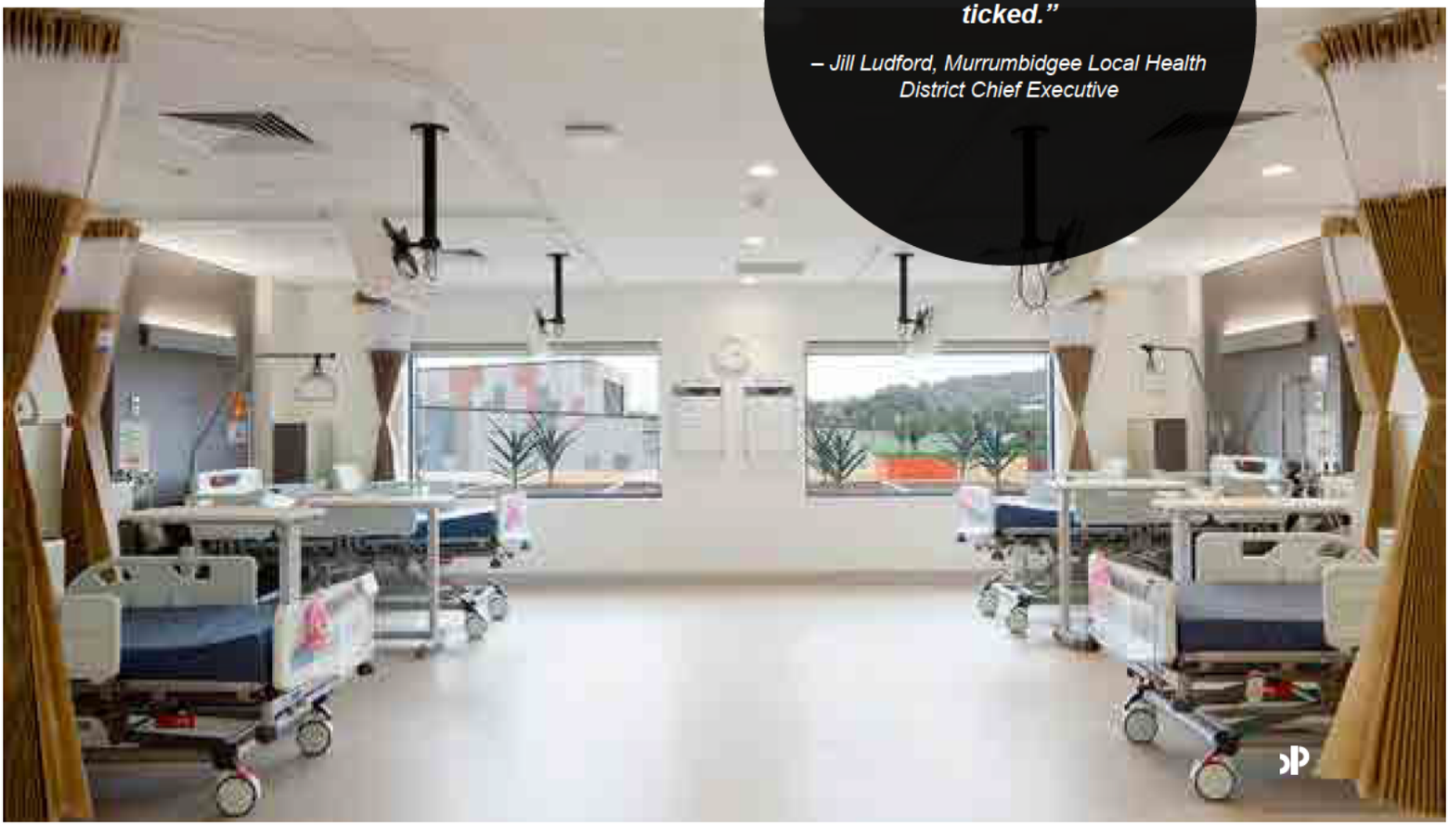
Part 2 Feasibility Development including Business Case and input into Gate 1 Strategic Review.

Part 3 Schematic Development including Clinical Design Development and input to Gate 2 Business Case.

Wagga Wagga Rural Referral Hospital Redevelopment, NSW

"I'm really delighted to say all of our wishlist has been ticked."

– Jill Ludford, Murrumbidgee Local Health District Chief Executive



2.0
Resources

Our team for the Campbelltown Hospital Redevelopment brings a depth of experience in health and a diverse skill set together in a comprehensive service offering.

Our Design Leadership team will comprise **Director-in-Charge Tara Veldman**, who will lead the project from visioning to completion, together with **Health Director Mark Mitchell** and with input from our international collaborator, **dJGA and our Design Director David Leece**.

Both Tara and Mark bring significant experience in large complex hospital design, having planned several major hospital campuses across Australia and internationally.

Additionally, Tara and Mark have in depth experience in Paediatrics and Mental Health facilities, they will oversee the strategic direction of the project, and provide health facility design intelligence throughout the project.

Global Knowledge, Applied Locally

BLP will collaborate with internationally renowned Master Planning and health design experts **de Jong Gortemaker Algra (dJGA)** Architects and Engineers from the Netherlands as international health advisors.

BLP has an established and trusted relationship with our partners. **Tara Veldman** worked for dJGA in The Netherlands between 1996 to 2004. Our combined experience and current practice in the design and delivery of this project type, complexity and scale both internationally and locally, has given our team the necessary skills and knowledge to deliver a world-class facility, appropriate to the needs and aspirations of the Campbelltown Macarthur community.

Perth Children's Hospital, Nedlands WA

Structuring the Team for Efficiency

Our resources have been carefully and deliberately structured into 4 dedicated teams to hit the ground running.

Master Planning and Urban Design Team

Clinical Planning Team

Interiors Fitout and Workplace Team

Infrastructure, Building Design & Facade Team

Our **Master Planning and Urban Design team** will be led by Director **Ron Billard**, highly regarded for his Master Planning work throughout Australia. Ron will be joined by **Dajon Veldman** providing a value add for the larger urban context of Campbelltown both will be involved in the vision definition, Master Planning and review the feasibility phase of the project.

Our **Clinical Planning team** will be led by **Matt Kenchington**, a senior architect with extensive experience in the design and delivery of hospitals and mental health facilities. He will be the main point of contact for Heath Infrastructure, SWSLHD and the Project Manager on clinical planning briefing, consultation and coordination from Master Planning through to completion. Matt will be supported in Schematic Design by 4 Clinical Planning sub teams working intensively in parallel, each led by experienced health architects:

Acute Services, led by **Megan Harris**

Inpatient Services, led by **Kathleen Hume**

Ambulatory and Diagnostic Services, led by **Katarina Vrdoljak**

Clinical and Non-Clinical Support Services, led by **Richard Hudson**

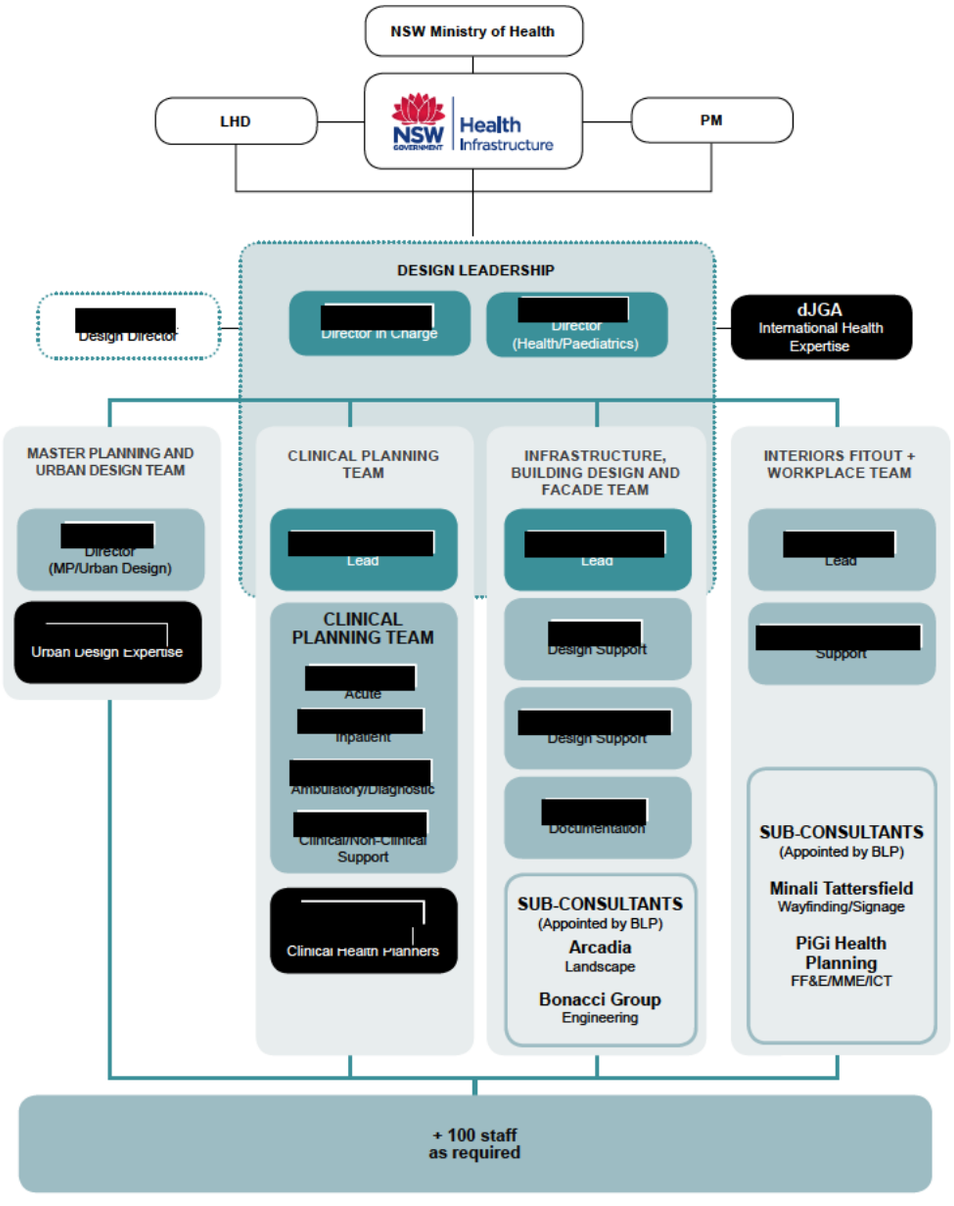
Our Interior Fitout and Workplace team will be led by **Vicki Murphie**, focusing on a flexible, contemporary and welcoming interior fitout and workplace strategy.

Adam Muggleton will lead the Infrastructure, Building Design and Façade Team, including building design, façade and public spaces. Adam will be supported by **Ariel Lopez** in design and **Simon David** in documentation delivery of well-resolved and buildable designs.

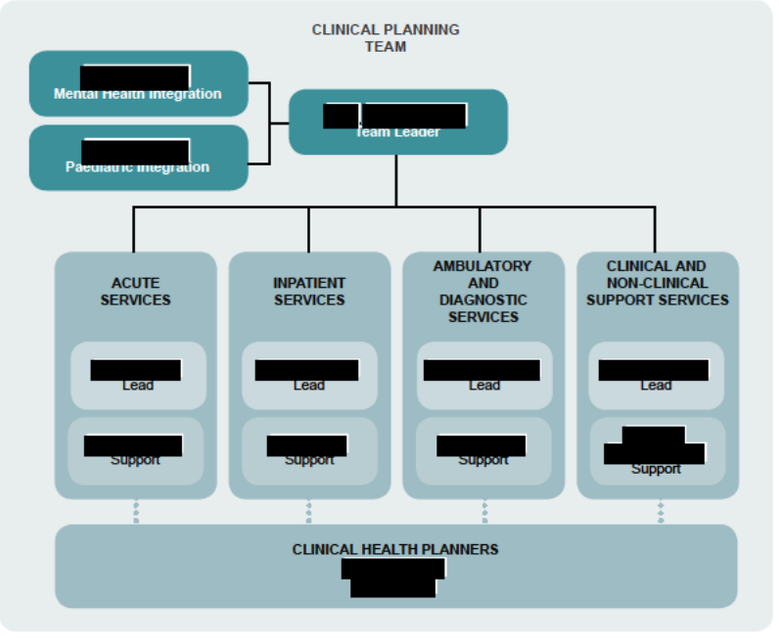
David Leece our Design Director will provide direction to this team.

Organisation Charts and a brief summary of our core team's skills and relevant experience are included in the following pages

Main Project Governance Structure Overview



Clinical Planning Detailed Team Structure



Design Leadership Team

[redacted]

de Jong Gortemaker Algra Architects - International Heath Expertise (dJGA)

Together with Henk de Jong and Maurits Algra and Femke Feenstra, Roelof Gortemaker makes up the management of De Jong Gortemaker, who are recognised for some of the world's most innovative and forward thinking Academic Health Science Centres (also referred to as "University Medical Centres" in the European context) throughout Europe, Asia and The Middle East. These include the flagship Erasmus Medical Centre Campus in the Netherlands – demonstrating world's best in Innovation, Jeroen Bosch Hospital – the most patient friendly hospital in the Netherlands, and Maxima Medical Center, Veldhoven in the Netherlands.

Master Planning & Design Team

[redacted]
Role: (MP/Urban Design)
M Arch, B Arch (Hons)

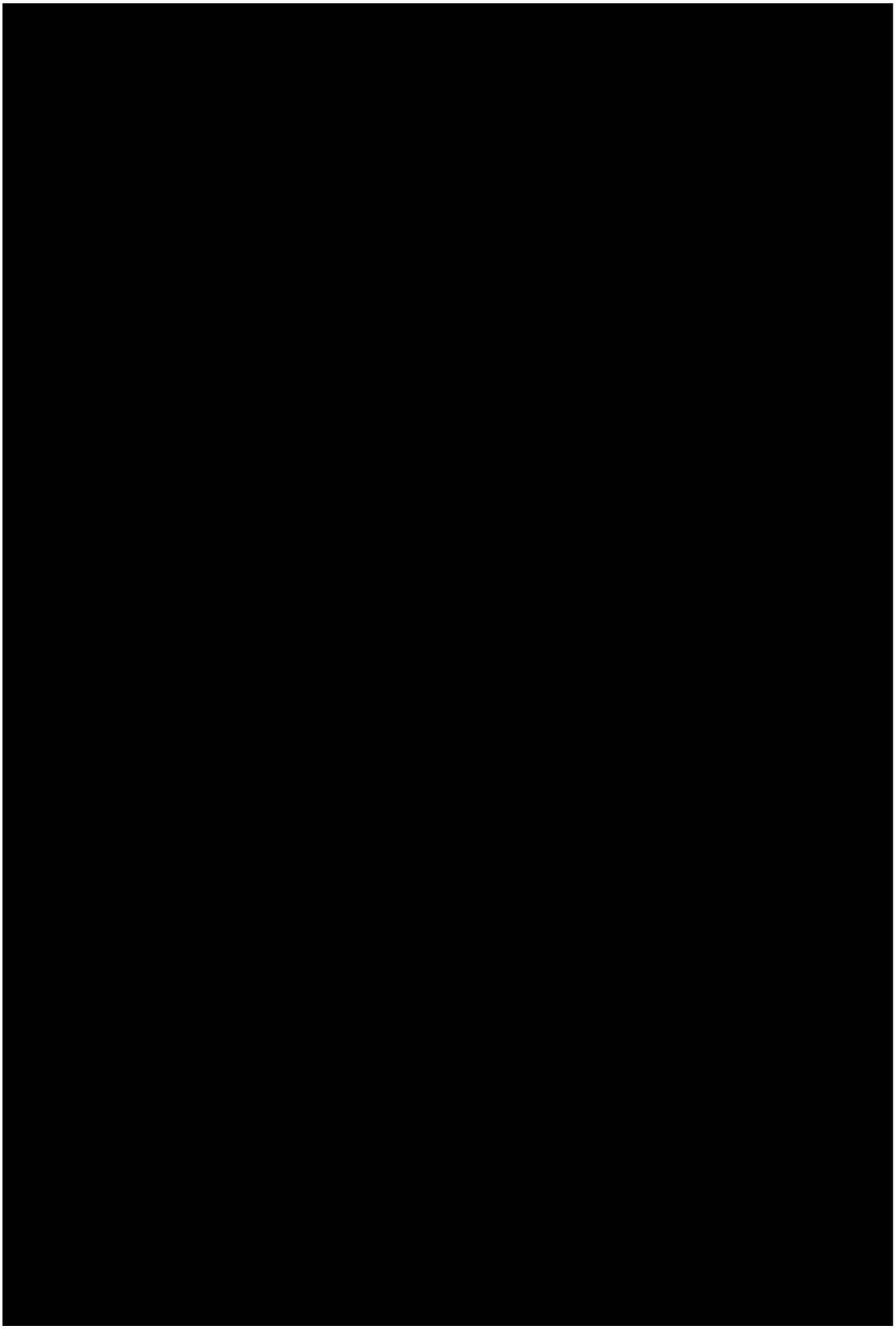
[redacted]
Role: Design Director
BSc Arch

[redacted]
Role: Urban Design Expertise
BS Arch (Hons)

[redacted]
Role: Interiors Fitout & Workplace Lead
BS Arch (Hons)

[redacted]

Clinical Planning Team



Clinical Planners

[redacted]

Subconsultants - Our Extended Team

Our projects are a success because of the people that work on them. BLP have assembled a team who have the right skills and expertise, experience working on large complex integrated hospital campuses, and with whom we regularly collaborate.

ARCADIA

Arcadia Landscape - Landscape Architect

Arcadia bring a depth of expertise in the health sector, providing attractive, functional, cost effective and environmentally sustainable solutions. We are currently working together on the University of Sydney Health Sciences Precinct Stage 1 and the recently completed the highly successful Wagga Wagga Rural Referral Hospital Stage 2 ($210m). Other health projects for HI include Shellharbour Hospital and Ku-Ring-Gai Hospital.

Minale Tattersfield - Wayfinding/Signage

Award-winning agency Minale Tattersfield work bring extensive and recent experience creating wayfinding and signage for major public health projects including Gosford District Hospital ($368m), Blacktown Hospital and Mount Druitt Hospital ($243m), Canterbury District Health Board NZ ($650m+) and Fiona Stanley Hospital WA ($2b); current health projects with BLP include the Bulli Aged Care Centre of Excellence ($44.6m).

BONACCI

Bonacci Group - Facade Engineer

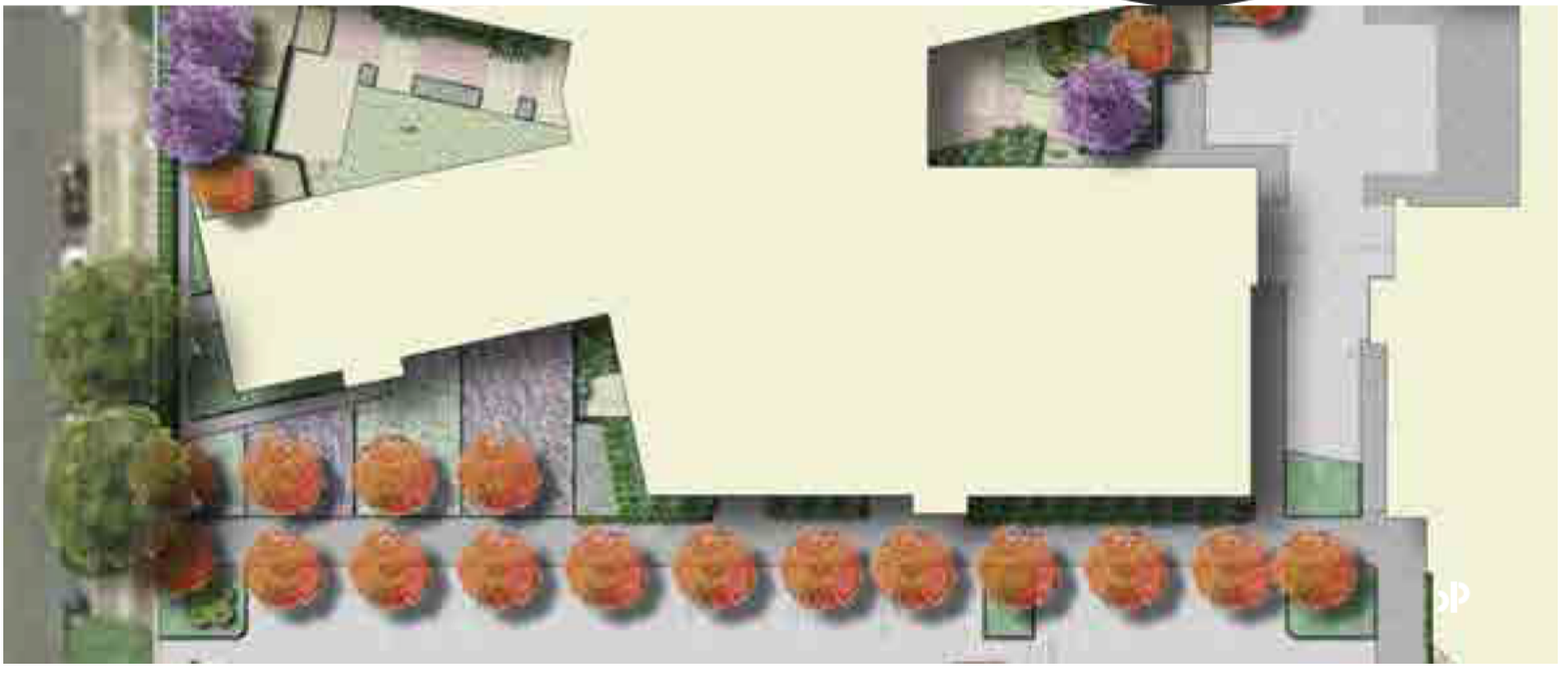
Our team has a strong working relationship with Bonacci Group, who bring highly relevant experience in the facade design of large public hospitals across Australia. Recent health projects with BLP include Wagga Wagga Rural Referral Hospital Stage 2 ($210m), Royal Children's Hospital Melbourne ($955m), and Goulburn Hospital ($120m); others include the Victorian Comprehensive Cancer Centre ($1.1b), Epworth Hospital ($700m), Nepean Hospital Redevelopment Master Planning ($600m).

PiGi Health Planning - FF&E/MME/ICT

Jo Pignatelli has delivered comprehensive planning and FF&E scheduling for several major projects for HI such as Blacktown Hospital and Mount Druitt Hospital ($243m), St George Hospital Stage 2 ($307m) and Tamworth Hospital Redevelopment ($211m); others include Royal North Shore Hospital Redevelopment ($450m) Royal Adelaide Hospital SA ($2.3b), Fiona Stanley Hospital WA ($2b).

Leaders in their respective fields of practice, they have become part of our core team across the health sector, and we are confident of our combined ability to deliver an outstanding result for Stage 2 at Campbelltown Hospital.

Mental Health Unit at Hornsby Hospital by Arcadia is a collaboration with the architects. The landscape design delivers a response to assist the recovery process for the patients. Two secured courtyards sit within the wings of the building providing external breakout space while retaining privacy and security.



3.0
Program and Milestones

Project Initiation

Master Planning Phase

Define the problem – Data Collection, Research and Benchmarking

The project will commence with a Team Start-up Workshop between key team members to confirm design programs and milestones, communication strategy, and the status of information needed to complete the project, including an update on the CSP with Paediatrics, and any additional site information outstanding for further data collection.

BLP have recently completed a gap analysis of site information, a review of the 2014 Master Plan, and a traffic management and car parking location study for the Campbelltown Hospital site, and will utilise this pre-design data to inform Master Planning.

Project aspirations are a key part of this phase and discussions with SWSLHD and Campbelltown Hospital, precinct stakeholders including UWS and the local council will be organised to gather their inputs.

The design team will also undertake research, precedent studies and benchmarking of innovative systems, technologies and space typologies in preparation for the first Master Planning Executive Working Group (MEWG) to define the project vision.

Coordination linked by project activities

Meetings

BLP has prepared a preliminary program showing all key meetings and milestones. It is very important to set up a dedicated schedule of meetings and review processes agreed at the beginning of the project to meet the tight program.

With Executive Steering Committee, Planning and Design Committee, Project Planning Team and Project User Group meetings coordinated with the design program, quick feedback will ensure the program can be adhered to.

The approval process must also be agreed and timetabled so the full consultant team can program work efficiently and to smoothly proceed to the next stage.

Stakeholder Meetings - Meeting the Program

BLP has the resources immediately available to undertake this work. All design work will be undertaken in our Sydney office for greatest access to sub consultants, the Project Manager and HI team.

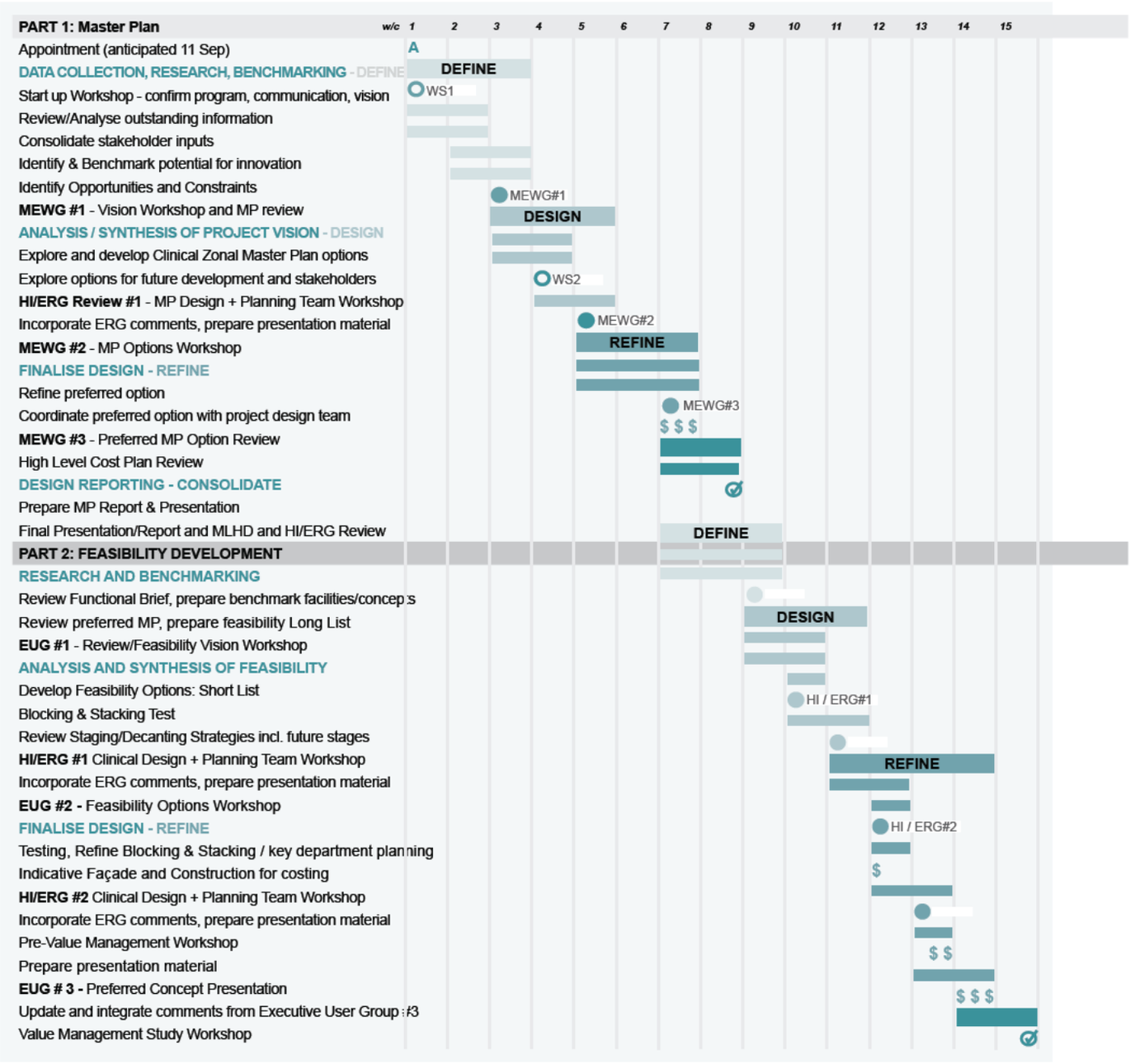
Design and documentation coordination meetings will initially be held in our Sydney studio to ensure ease of attendance for the project team and allow quick turnaround of information.

BLP anticipates that a project office will be established at Campbelltown Hospital. Having a project office on site will ensure ready access to key stakeholders for best possible communication outcomes. It will also provide an environment that allows the project team to be fully focussed.

BLP does not produce any design or documentation deliverables off-shore for Government projects, which ensures a greater certainty in the quality of documentation as well as a sustainable approach to the local economy in the retention of our healthcare expertise.

A preliminary draft program for the whole project, showing all key meetings and milestones is attached in Appendix A

Program and Milestones Table



4.0
Key Deliverables

MEWG #1: Vision Workshop

This is a Vision Workshop and Master Plan Review session to establish key project objectives and drivers, develop a collective vision for the project and identify risks, opportunities and constraints. This Vision Workshop is a meeting that will included a broad cross section of Stakeholders, Value Add project personnel and redevelopment team to ensure innovation. The outcome of MEWG#1 will be to establish an over arching project vision brief.

options - Analyse and Synthesise Vision

The team will prepare concept options in context of the project vision brief established in MEWG #1, and based on the data collected on the site's opportunities and constraints, future flexibility and expansion, and innovation benchmarking and research. Options will take into account clinical zoning and consideration of external stakeholder project aspirations.

MEWG #2: Options Workshop

Master Plan Options Workshop, including design options for clinical adjacencies, car parking and traffic management across the site, interaction with the community and opportunities for interaction with other precinct partners. This will inform a preferred option to further refine.

The team will refine the preferred option as selected during MEWG #2, updated to incorporate client feedback. The preferred option will be coordinated with input from the wider design team, and staging and future development will be tested as well as flexibility and robustness of the option for various scenarios in preparation for concept design.

MEWG # 3: Preferred Option

The team will present and workshop the preferred option for final endorsement as a base design, including any enhancements or further development of the option. The outcome of the workshop will be an endorsement of the Master Plan Strategy ready for final consolidation.

The final phase of the Master Plan will consolidate the information into a report and presentation for endorsement, and to inform the following Feasibility and Schematic Design phases.

Feasibility Phase

In Feasibility, we will work to a similar ethos and methodology i.e. Define, Design, Refine, Consolidate.

In order to achieve the program, we have overlapped 2 weeks of Master Planning and Feasibility when we will collect, review and prepare information in time for the first Feasibility Executive User Group after the completion of Master Planning.

The design component of the feasibility phase will be completed by December 2017, allowing time for the business case to be completed by February 2018.

The team's activities in feasibility phase would build on the Master Plan and visioning components of the project, testing these ideas and concepts with stakeholders and the project design team to ensure clinical outcomes, buildability, staging, and cost certainty for the business case.

Schematic Design Phase

Starting in January 2018, Schematic Design would overlap with business case preparation, and will test and validate the concept design phase with extensive detailed consultation with the users.

We have organised our Clinical Planning team into 4 streams to hit the ground running, and ensure coverage of all aspects of the project to meet the program:

Acute Services

Inpatient Services

Ambulatory and Diagnostic Services

Clinical and Non-Clinical Support Services

Working in parallel, our Infrastructure, Building Design and Façade and Interior Fitout and Workplace teams will be strategising and resolving the design detail of the project.

A meeting schedule and outputs for the whole project, is attached in Appendix B

5.0
Documentation Required and Timing

The key outcomes for Parts 1 to 3 are outlined below.

Master Planning

- Prepare Service Delivery Plan
- Contribute to Project Risk Management Plan
- Information and Reference Document review and recommendation report
- Prepare a Zonal Master Plan
- Review and contribute to High Level Schedule of Accommodation.
- Develop Site Massing options and building form interpretations.
- Prepare a Master Plan Report

Feasibility

- Prepare Concept Design Report
- Update BIM Management Plan
- Contribute to Value Management Study
- Long and Short Lists of possible options.
- Develop reasons and document the benefits of selected option(s).

Schematic Design

- Prepare Schematic Design Report including Value Engineering Report.
- A BIM Model
- Update BIM plan.
- Prepare a System and Equipment List.

Systems and Equipment

Systems and Equipment include FF & E, ICT and MIME. During this Stage we will contribute to the Systems and Equipment Pan – a methodology for identification right through to procurement and commissioning.

KEY DATES

	START	FINISH
Part 1 Master Planning	**23/10/2017**	**22/11/2017**
Final Master Plan Report		22/11/2017
Part 2 - Concept Design /Fesibility	**25/9/2017**	**24/4/2018**
Planning Validation Process	27/9/2017	25/10/2017
Functional Design Brief Process (FDB)	25/10/2017	12/12/2017
FDB including SOA Completed		12/12/2017
Option Development - Agree Preferred Option	25/10/2017	9/11/2017
Value Management Study (VMS)	15/11/2017	22/11/2017
Preferred Concept Design Option - Agreed		23/11/2017
Develop Concept Design / Concept Design Report	27/10/2017	8/12/2017
Concept Design Report Complete		8/12/2017
Business Case - Development	25/9/2017	12/12/2017
BIM Plan	23/11/2017	12/12/2017
LHD Deliverables developed	23/10/2017	29/11/2017
Business Case - Writing & Drafting	24/11/2017	12/1/2018
Issue Final Business Case for INSW Review		12/1/2018
Gateway Review	29/10/2018	6/3/2018
Business Case - to MoH	7/3/2018	27/4/2018
Part 3 Schematic Design	**8/12/2017**	**18/6/2018**
Schematic Design	8/12/2017	9/4/2018
Clinical Design Development (CDD)	27/3/2018	18/6/2018
Town Planning	**30/1/2018**	**29/6/2018**
Construction Commence Indicative		**31/5/2018**

Maxima Medical Centre Veldhoven, NLD

Maxima Medical Centre by dJGA is a pioneer in the field of women and children's health, one of the world's first centres to include rooming-in facilities for mothers and babies based on extensive research on better clinical outcomes by the team.

6.0
Consultation Strategy

BLP see the stakeholder engagement process as a crucial part of the research and innovation of a project. Success depends on the commitment and enthusiasm of all stakeholder groups.

Our approach to the Campbelltown Hospital Redevelopment will be coordinated to ensure that everyone is informed about the project and has the opportunity to input into the process. The building of positive relationships between team members and stakeholders and their buy in to the result is integral to the success of the project.

BLP's experience designing for health organisations across large redevelopments has equipped us with the tools and processes to manage communications strategies for Campbelltown including:

Vision Workshops to bring together stakeholders and discuss ideas and strategies, blue sky thinking and ensuring different perspectives are taken into consideration. Innovative ideas for the Campbelltown Hospital will be born in these workshops

Effective Management of meetings and information, ensuring people have the information they need to make decisions

Clear Communication of concepts and ideas in simple terms so everyone understands the proposals as they are being worked up. Use of diagrams, sketches, examples and benchmarks to describe ideas and welcoming others input into the ideas and concepts.

Visualisation Techniques that allow clients, stakeholders and users to see, experience and understand the design of the built environment. A combination of 2D, 3D and multimedia imagery enhances the understanding of design option proposals. These tools also have a role in client/ stakeholder support in broader community engagement and managing government expectations

In-house Clinical Health Planners underpin all health planning and design at BLP. They have a depth of knowledge gathered from hands on experience in clinical operation. They facilitate simple interpretation of clinical issues, allow the focus to be on solutions and ultimately distil the valuable time invested by the client as efficiently as possible.

Stakeholder Consultation

Consultation with stakeholders is key to the success of this project, particularly in light of the extensive growth envisaged for Campbelltown as the Western City – the third city centre for Sydney – and the Badgerys Creek airport development, which will position the hospital as a key player in health delivery in NSW.

Our team will contribute to the stakeholder consultation plan, attend and lead workshops as required, incorporate ideas and feedback into the design and reporting for the project and consult with multiple diverse stakeholder groups.

Campbelltown Hospital and LHD project stakeholder communications as defined within the HI governance structure include the Master Planning Executive Working Group (MEWG), Planning and Design Committee (P&DC), Project Planning Team (PPT), and Project User Groups (PUGs) meetings. We will be present at meetings as required and would organise and facilitate the Project User groups in conjunction with the Project Manager and the LHD.

The **Master Plan Executive Working Group (MEWG)** will be actively engaged in the planning stages through structured workshops. Together with the MEWG, we will set the overall direction for the project and we would expect this group to be involved throughout Master Planning and feasibility phases. During the feasibility stage this group will contribute directly to the project design briefs, blocking and stacking, zoning of departments and flows.

Project User Groups (PUGs) will be actively engaged in the Schematic Design and Clinical Developed Design stages through structured workshops. When working with User Groups, it is important to explain the process, flag when actions/decisions have to be made, and carefully document each meeting and step along the way. We will present our User Group Tool Kit to facilitate this process. During the schematic design stage, they will focus on departmental planning and schedules of accommodation.

In addition to the above groups defined under governance, BLP will facilitate Architectural Working Groups to ensure that the design of the hospital is communicated to the key members of the hospital and SWSLHD redevelopment team and executive. The membership of this group can be broad and should include key people from the hospital redevelopment team.

Communication within Health Infrastructure

This will include the presentations to the Expert Review Group (ERG) and ongoing discussions with the HI clinical solutions group. We have worked extensively with both groups, and greatly value our interactions and the expertise these groups bring to the table.

7.0
Monthly Reporting and Formats

Reports

Regular Reports

Reports will be prepared at the end of Masterplanning, Feasibility (Concept Design Report) and Schematic Design (Including Value Engineering) phases. A 40% and 70% issue is also programmed in. A BIM management plan will be developed and updated at each phase. These standalone reports can be easily read by those who might not be involved in the regular workshops. They will record options considered and reasons why preferred options were selected.

Project Program: Locked In

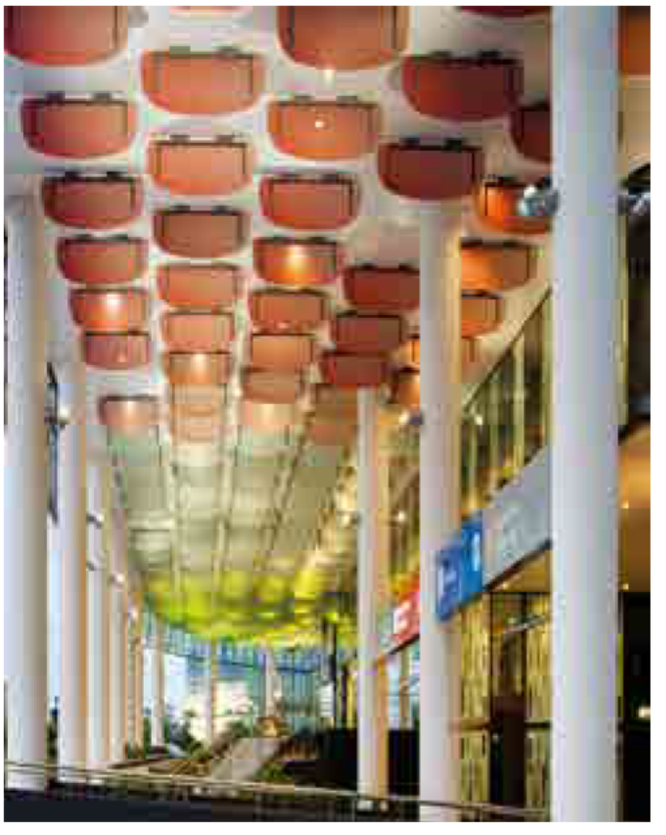
At the start of the project a program will be confirmed so meetings and workshops can be locked in. This will enable diaries of key stakeholders to be coordinated to allow their participation and ensure full communication of progress.

Monthly Project Status Reports

Monthly design status reports will be prepared to summarise decisions made key milestones for the next month and decisions outstanding that may impact on the program. These will inform the Project Manager's monthly reports.

Presentation to External Stakeholders: Local Government, State Departments and Community Groups.

At key milestones presentations will be prepared for wider government consultations. These need to be determined by the project team.



8.0
Quality Assurance

Design Management

BLP have extensive experience acting as Principal Consultant on several projects of a similar type, scale and complexity to the Campbelltown Hospital Redevelopment. We will work hand in hand with the Project Manager to ensure consultant design input is managed in a timely manner.

Regular fortnightly design coordination meetings will be supplemented with Design and Technical workshops with specific consultants as required to quickly identify and workshop areas of scope that need to be addressed and resolved. Action items will be addressed and tracked via an agenda, and project information will be issued to the team regularly for information. Adam Muggleton, our dedicated Infrastructure, Building Design and Facade Team Leader, will oversee and coordinate consultant input and ensure deadlines are being met.

Documentation Management and BIM (Building Information Modelling)

BLP will design and document the project using Building Information Modelling. There are many definitions of Building Information Modelling (BIM), but it is simply the means by which everyone can understand a building through the use of a digital model. Modelling an asset in digital form enables those who interact with the project and the building to optimize their actions, resulting in a greater whole life value for the asset. The model can be used to present the design, and also to analyse components of the project to ensure robust coordination and costing.

BLP uses industry-standard BIM tools such as Autodesk Revit for design and documentation, dRofus for space planning & FFE management, and Aconex file sharing platform for communication & coordination. Our BIM workflow also extends to our consultants and contractors, ensuring that all project partners & disciplines are kept up to date with the latest vision for the project.

Structured Consultants Work Plan

As coordinating design consultant, we will develop a project management plan with the other consultants to outline the process and ensure consistency in approach in production, coordination and distribution of documentation and reports.

BLP will manage Design Coordination with Documentation Background Releases and ‘Freeze’ Points. We will host clash coordination sessions with the project design team, issue building models via Aconex and coordinate/clash detection sessions as required.

Use a Web-based Common Network System for Document Sharing

Aconex will be used for team wide document distribution. Filing systems will be governed by our Certified Quality Management Systems (QMS) incorporating our Quality Procedures Manual.

Project Specific Quality Plan (PSQP)

BLP's control document will be tailored specifically to the Campbelltown Hospital Redevelopment with consultation with the Project Manager. The document is periodically updated, enables anyone new to the project to be fully inducted, outlines the governance, protocols, and any issues with confidentially.

Facility Planning Process

BLP are highly experienced with the PoFP and HI’s approach, and will actively engage with the framework to successfully achieve each milestone.

In addition to the deliverables and activities specified for each stage, BLP will address the clinical and operational challenges in the Campbelltown Hospital facility planning process as follows:

Enhancing facilities to develop an integrated health service and implement contemporary clinical service models of care

Separation of clinical and non-clinical travel

Good wayfinding, signage and interior graphics

Well planned clinical areas, including staff zones

Incorporation of new technologies

FF&E, MME and ICT is a significant part of the budget - we have included specialist advisors in our team for both FF&E, and for MME and ICT integration

Meeting the community’s expectations for convenient, inclusive, accessible and high quality services which are designed in a manner which recognises the clinical and cultural needs of the community

Flexibility to maximise multi-use spaces, adaptability and expansion

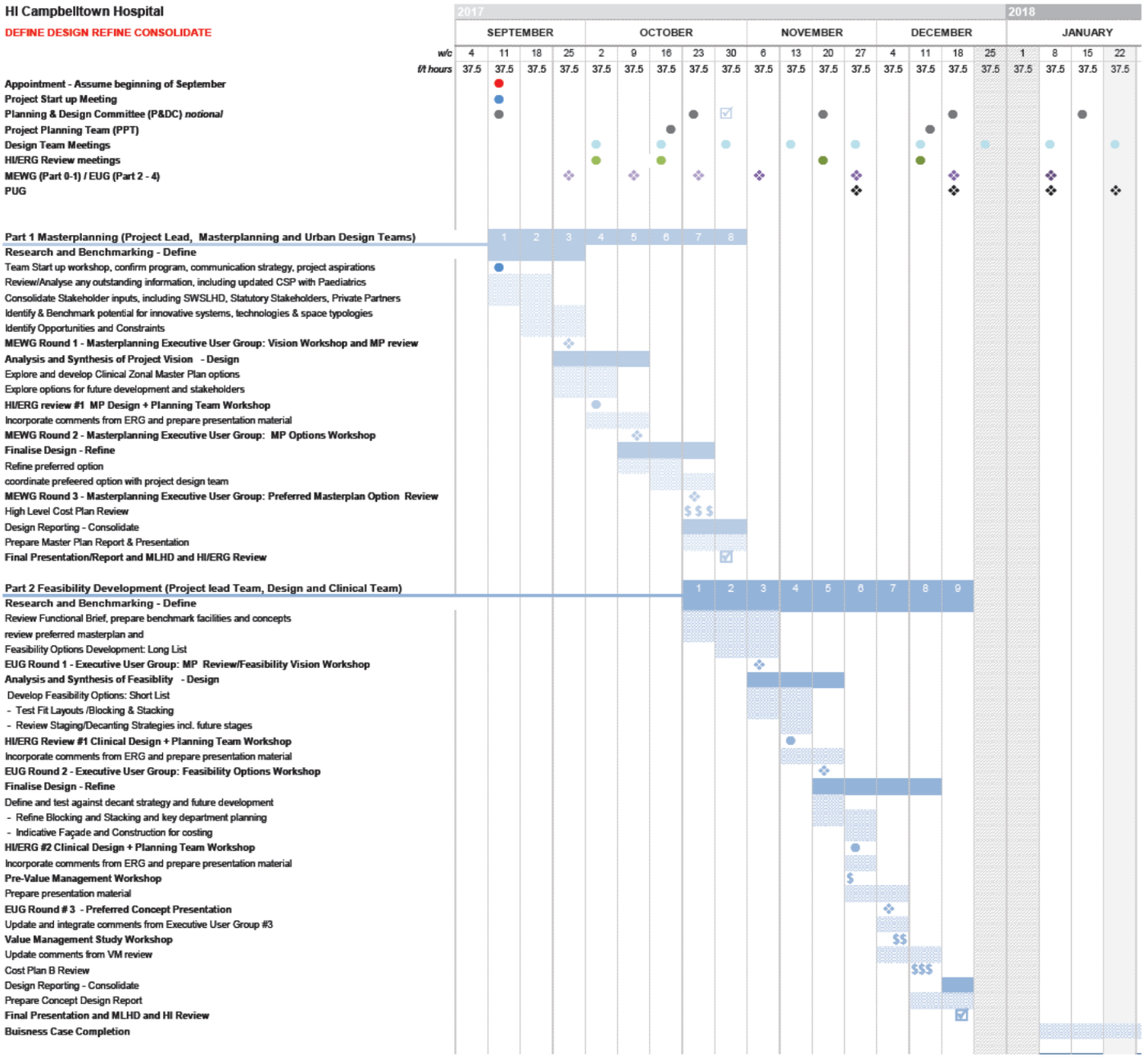
Maintainability to reduce recurrent costs and energy expenditure

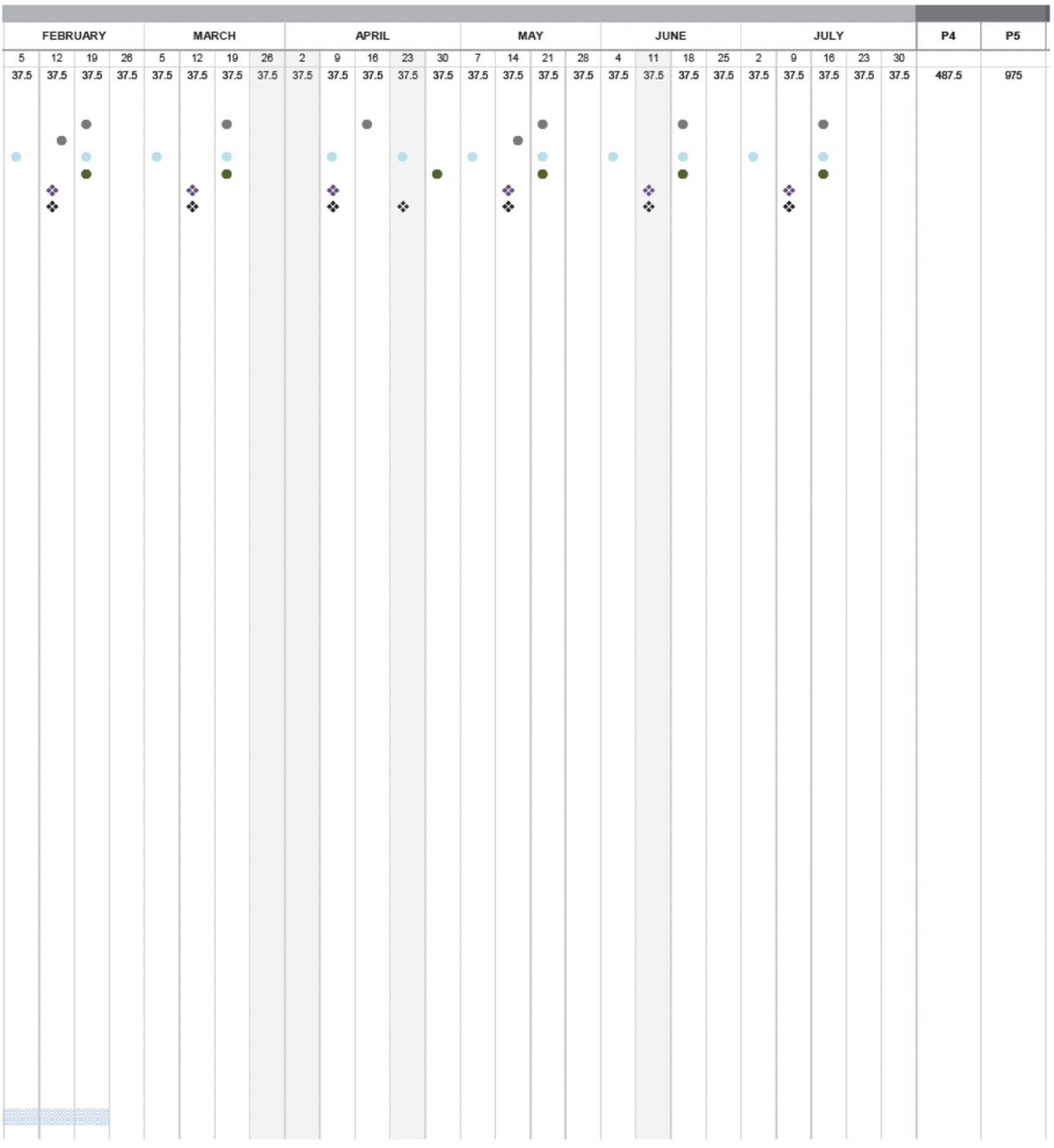
Consideration of links to existing buildings, the wider hospital and future development stages - an important consideration will be the links to the Stage 1 redevelopment to ensure the investment is optimised.

Crime Prevention Through Environmental Design (CPTED) - A design guideline to design environments safely

10.0
Appendices

Appendix A
Program

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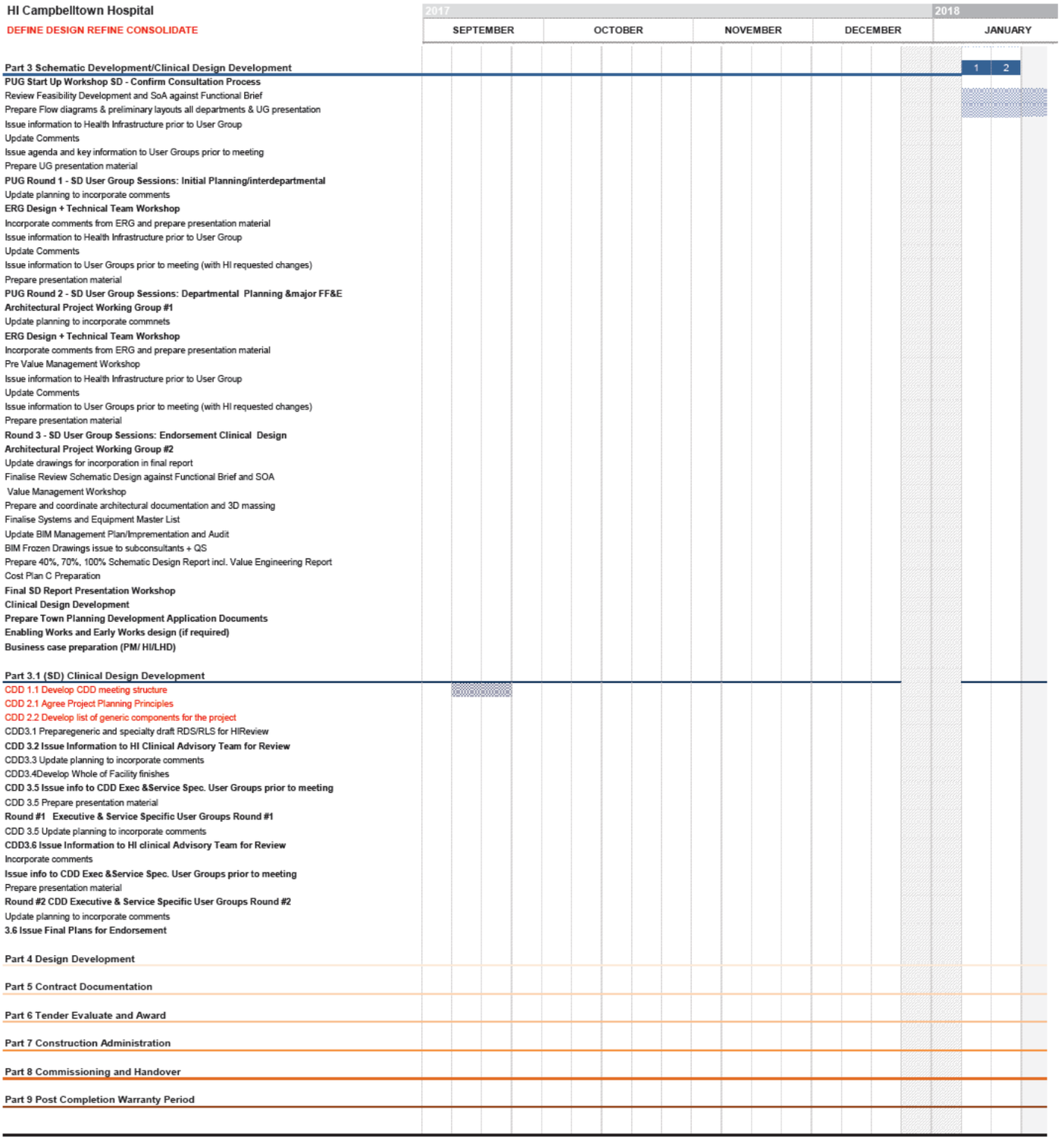
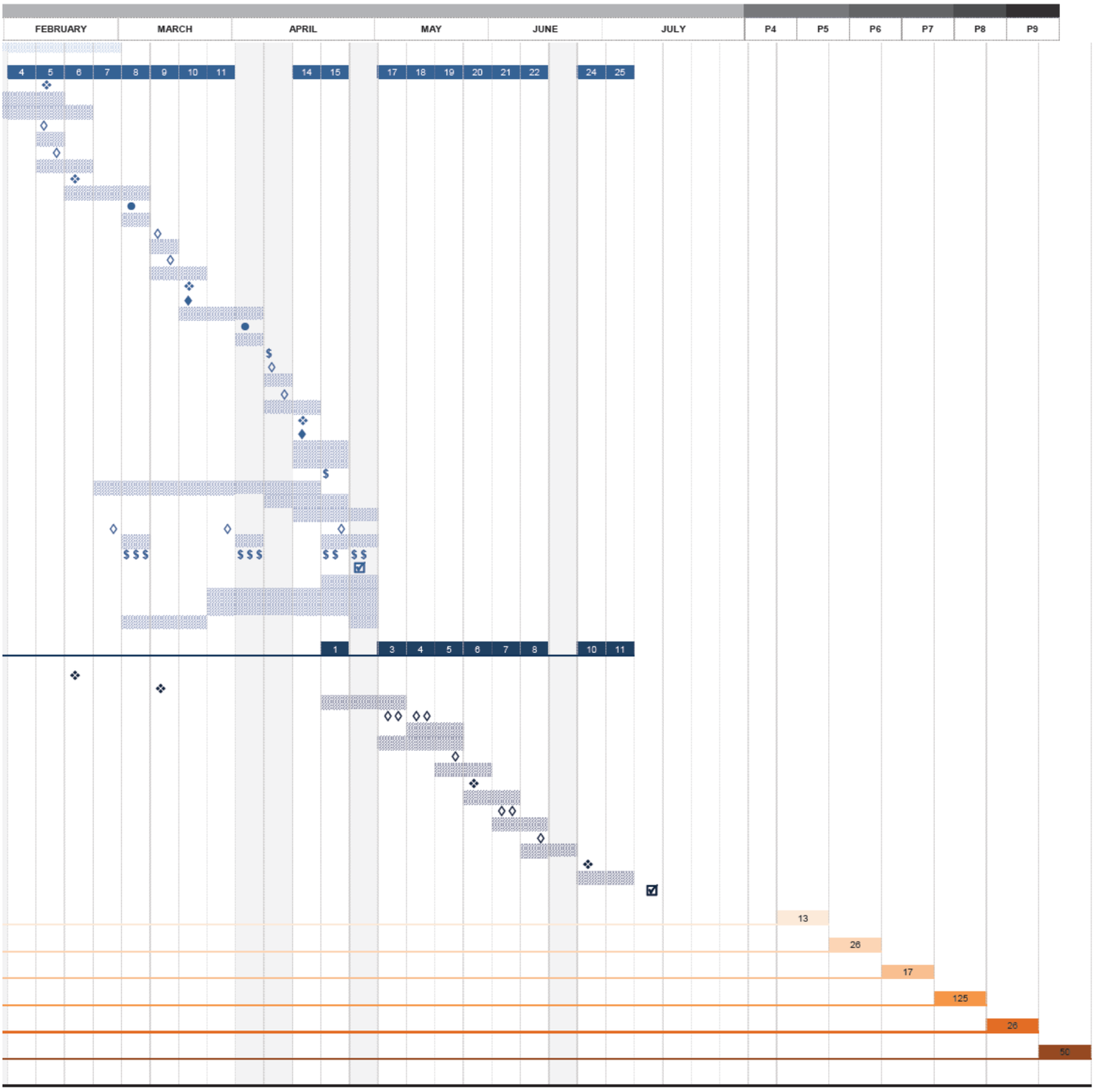
Program


HI Campbelltown Hospital
DEFINE DESIGN REFINE CONSOLIDATE
2017
2018
SEPTEMBER
OCTOBER
NOVEMBER
DECEMBER
JANUARY
1
2
Part 3 Schematic Development/Clinical Design Development
PUG Start Up Workshop SD - Confirm Consultation Process
Review Feasibility Development and SoA against Functional Brief
Prepare Flow diagrams & preliminary layouts all departments & UG presentation
Issue information to Health Infrastructure prior to User Group
Update Comments
Issue agenda and key information to User Groups prior to meeting
Prepare UG presentation material
PUG Round 1 - SD User Group Sessions: Initial Planning/interdepartmental
Update planning to incorporate comments
ERG Design + Technical Team Workshop
Incorporate comments from ERG and prepare presentation material
Issue information to Health Infrastructure prior to User Group
Update Comments
Issue information to User Groups prior to meeting (with HI requested changes)
Prepare presentation material
PUG Round 2 - SD User Group Sessions: Departmental Planning &major FF&E
Architectural Project Working Group #1
Update planning to incorporate commnets
ERG Design + Technical Team Workshop
Incorporate comments from ERG and prepare presentation material
Pre Value Management Workshop
Issue information to Health Infrastructure prior to User Group
Update Comments
Issue information to User Groups prior to meeting (with HI requested changes)
Prepare presentation material
Round 3 - SD User Group Sessions: Endorsement Clinical Design
Architectural Project Working Group #2
Update drawings for incorporation in final report
Finalise Review Schematic Design against Functional Brief and SOA
Value Management Workshop
Prepare and coordinate architectural documentation and 3D massing
Finalise Systems and Equipment Master List
Update BIM Management Plan/Impremention and Audit
BIM Frozen Drawings issue to subconsultants + QS
Prepare 40%, 70%, 100% Schematic Design Report incl. Value Engineering Report
Cost Plan C Preparation
Final SD Report Presentation Workshop
Clinical Design Development
Prepare Town Planning Development Application Documents
Enabling Works and Early Works design (if required)
Business case preparation (PM/ HI/LHD)
Part 3.1 (SD) Clinical Design Development
CDD 1.1 Develop CDD meeting structure
CDD 2.1 Agree Project Planning Principles
CDD 2.2 Develop list of generic components for the project
CDD3.1 Preparegeneric and specialty draft RDS/RLS for HIReview
CDD 3.2 Issue Information to HI Clinical Advisory Team for Review
CDD3.3 Update planning to incorporate comments
CDD3.4Develop Whole of Facility finishes
CDD 3.5 Issue info to CDD Exec &Service Spec. User Groups prior to meeting
CDD 3.5 Prepare presentation material
Round #1 Executive & Service Specific User Groups Round #1
CDD 3.5 Update planning to incorporate comments
CDD3.6 Issue Information to HI clinical Advisory Team for Review
Incorporate comments
Issue info to CDD Exec &Service Spec. User Groups prior to meeting
Prepare presentation material
Round #2 CDD Executive & Service Specific User Groups Round #2
Update planning to incorporate comments
3.6 Issue Final Plans for Endorsement
Part 4 Design Development
Part 5 Contract Documentation
Part 6 Tender Evaluate and Award
Part 7 Construction Administration
Part 8 Commissioning and Handover
Part 9 Post Completion Warranty Period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Appendix B
Meeting Schedule and Outputs

	16-Oct	17-Oct	18-Oct	19-Oct	20-Oct	23-Oct	24-Oct	25-Oct	26-Oct	27-Oct	30-Oct	31-Oct	1-Nov	2-Nov	3-Nov	6-Nov	7-Nov	8-Nov	9-Nov	10-Nov	13-Nov	14-Nov	15-Nov	16-Nov	17-Nov	20-N
	Mon	Tues	Wed	Thurs	Fri	Mon	Tues	Wed	Thurs	Fri	Mon	Tues	Wed	Thurs	Fri	Mon	Tues	Wed	Thurs	Fri	Mon	Tues	Wed	Thurs	Fri	Mo
Governance																										
ESC																			#4 2-3pm							
PDC									#4 4-6pm										#5 10-12pm							
LHD Executive Group (AL/AD/DR/SH/SP)																										
Clinical Reference Group (CRG) (Monthly - Friday)																										
Clinical Reference Working Group (CRWG)			#3 2- 4pm					#4 10-12pm					#5 2- 4pm					#6 3- 5pm				#7 9-11am			
Senior Managers Meeting	8:30 - 9am					8:30 - 9am					8:30 - 9am					8:30 - 9am					8:30 - 9am				
Mental Health Executive Group	#2 2-3pm					#3 2-3pm																				
Macarthur Community Representatives (existing)																										
Indigenous Community Representatives (existing)		3:30 - 4:30pm																								
Expert Reference Group (ERG)																TBC										
Gateway Review (Jan 2018)																										
Value Management Study																										
Options Identification / Value Management Preparation								#1 12-6pm	#1 8-4pm				#2 8-6pm	#2 8-6pm				#3 8-6pm	#3 8-6pm				VMS (TBC)			
Service & Facility Planning - Project User Groups																										
Clinical Stream #1 8.30 - 10.30am - Emergency Dept. 11.00 - 1.00pm - Intensive Care 2.00 - 4.00pm - Inpatient Surgical 4.00 - 4.30pm - Debrief																		#1 8.30-4.30pm								
Clinical Stream #2 8.30 - 10.30am - Perioperative Services. 11.00 - 1.00pm - Maternity Services 2.00 - 4.00pm - Endoscopy & Procedural 4.00 - 4.30pm - Debrief																		#2 8.30-4.30pm								
Clinical Stream #3 8.30 - 10.30am - Ambulatory & Day Medical 11.00 - 1.00pm - Central Sterilizing Service 2.00 - 4.00pm - Soft Facilities Management 4.00 - 4.30pm - Debrief																		#3 8.30-4.30pm								
Clinical Stream #4 8.30 - 10.30am - Inpatient Medical 11.00 - 1.00pm - Medical Imaging 2.00 - 4.00pm - Cancer Services 4.00 - 4.30pm - Debrief																			#4 8.30-4.30pm							
Clinical Stream #5 8.30 - 10.30am - Paediatrics 11.00 - 1.00pm - Special Care Nursery 2.00 - 4.00pm - Research & Education 4.00 - 4.30pm - Debrief																			#5 8.30-4.30pm							
Clinical Stream #6 8.30 - 10.30am - Outpatients 11.00 - 1.00pm - Other Back of House Services 2.00 - 4.00pm - Staff Amenities inc. Office Accom. 4.00 - 4.30pm - Debrief																			#6 8.30-4.30pm							
Clinical Stream #7 8.30 - 10.30am - Acute - MH Inpatient Adults 11.00 - 1.00pm - MH Inpatient Adolescent 2.00 - 4.00pm - Subactute MH 4.00 - 4.30pm - Debrief																			#7 8.30-4.30pm							
SWSLHD Working Groups																										
Communications Working Group - SH						#2										#3										#4
Technology Working Group - DR	#2										#3										#4					
Workforce Planning -						#2										#3										#4
Change Management & Benefits Realisation - LR						#2										#3										#4
Financial Impact Statement - AD					#4 9-10am					#5 9-10am				#6 9-10am						#7 9-10am				#8 9-10am		
Cost Benefit Analysis (CBA) - SH	#1										#2										#3					

Scheduled Meeting
Meeting TBC
VMS Workshop
Project User Group Meeting

...ov	21-Nov	22-Nov	23-Nov	24-Nov	27-Nov	28-Nov	29-Nov	30-Nov	1-Dec	4-Dec	5-Dec	6-Dec	7-Dec	8-Dec	11-Dec	12-Dec	13-Dec	14-Dec	15-Dec	18-Dec	19-Dec	19-Dec	21-Dec	22-Dec
...on	Tues	Wed	Thurs	Fri	Mon	Tues	Wed	Thurs	Fri	Mon	Tues	Wed	Thurs	Fri	Mon	Tues	Wed	Thurs	Fri	Mon	Tues	Wed	Thurs	Fri
													#5 2:30 - 3:30pm											
			#6 4-6pm					#7 9-11am																
									#3 - 3:00 - 5:00pm TBC															
		#8 10:30 - 12:30pm					#9 9-11am					#10 8-5pm												
...0 - ...m					8:30 - 9am					8:30 - 9am					8:30 - 9am					8:30 - 9am				
												3 - 5pm												
	3:30 - 4:30pm																				3:30 - 4:30pm			
					TBC																			
		Post-VMS (TBC)																						
		#1 8.30-4.30pm										#1 8.30-4.30pm												
		#2 8.30-4.30pm										#2 8.30-4.30pm												
		#3 8.30-4.30pm										#3 8.30-4.30pm												
			#4 8.30-4.30pm										#4 8.30-4.30pm											
			#5 8.30-4.30pm										#5 8.30-4.30pm											
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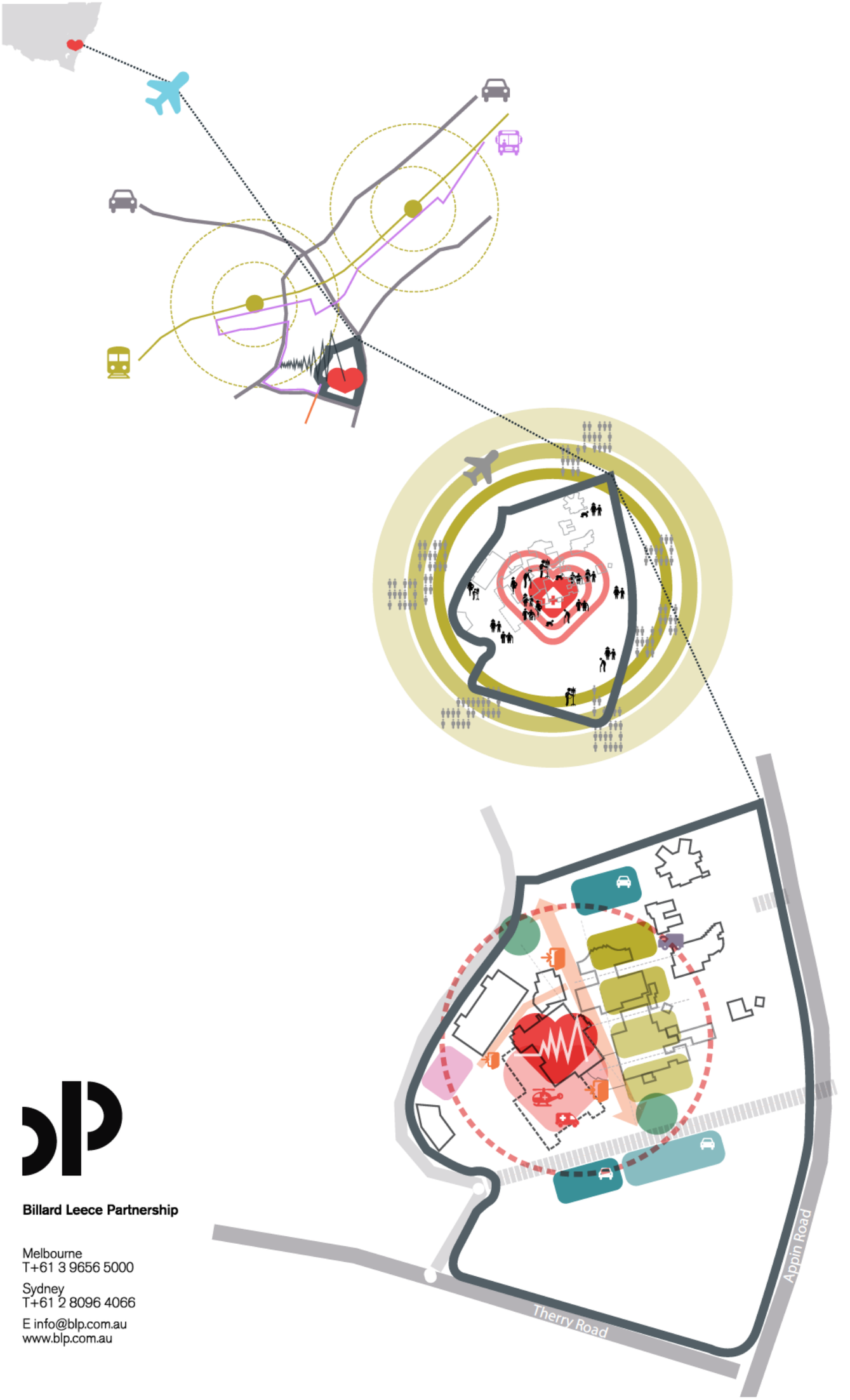
					#4					#5														



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18.2 App 02 - Services Delivery Plan – Cost Manager

Services Delivery Plan

Campbelltown Hospital Stage 2 Redevelopment

Version	Date	Issued By	Issued To	Status
0	20.09.17	[redacted]		DRAFT

Table of Contents

1. Introduction

The Campbelltown Hospital Stage 2 redevelopment works comprises of the increased capacity for paediatric and mental health services.

The Cost Manager is responsible for cost management throughout the Project including interface and integration with other team members of the project team, cost reporting, cost management and cost advice for all Parts 1 to 3 as detailed in the Scope of Services (Section 4):

- Part 1.0 – Master Planning
- Part 2.0 – Feasibility Development
- Part 3.0 – Schematic Development

2. Resources

AECOM resources on this project are as per our fee proposal to HI dated 27.07.17. We have listed out the key personnel below.

- [redacted] – Technical Director (Director in Charge)
- [redacted] – Technical Director (Peer Review)
- [redacted] – Associate (Team Lead)
- [redacted] – Associate (Whole of Life / Benchmarking)
- [redacted] – Senior QS (QS Support & Commercial/Buildability Specialist)
- [redacted] – Senior QS (BIM Specialist)
- [redacted] – MEP QS (Engineering Services)

3. Programme and Milestones

Project programme as per draft programme issued by the PM Root Partnerships which currently shows the project start date for Part 1 being September 2017 and the end date being June 2018.

Milestones with regards to the cost management component will relate to the preparation of Cost Plan A, Cost Plan B, Schematic Cost Plan C1 and the preparation of Cash flows, Life Cycle Costs and Cost Reports to meet the required programme dates.

4. Key Deliverables

Please see below list of key deliverables

Part 1 Planning

- Review and validate original Master plan
- Continuously monitor and assess key decisions and plans
- Prepare benchmarks used in preparation of Cost plan A
- Prepare Cost Plan A
- Advise elemental Cost Targets
- Prepare Cash flows and Monthly Cost Report
- Review and advise Project Risks

Part 2 Feasibility

- Continuously monitor and assess key decisions and plans
- Prepare Cost Plan B
- Prepare full cost analysis that examines capital, recurrent and life cycle costs for each option developed for the project
- Prepare reconciliation to previous Cost plan
- Prepare and attend Value Engineering Workshop
- Advise elemental Cost Target
- Prepare Cash flows and Monthly Cost Report
- Review and advise Project Risks

Part 3 Schematic Development

- Continuously monitor and assess key decisions and plans
- Prepare Cost Plan C1
- Prepare Cash flows and Monthly Cost Report
- Prepare Systems and Equipment Cost Report
- Prepare Lifecycle Cost Report
- Review and advise Project Risks
- Participate in Value Engineering Study
- Advise on relevant input and information into Schematic Design Report and Business Case

5. Consultation strategy and site presence

Attend design meetings as required in the preparation of the cost estimate and other cost management deliverables.

Attend site for meetings as required no full time site presence required.

6. Documentation required and timing

Prepare and provide the key deliverables as mentioned in section 4 as per the approved programme timeframe.

7. Monthly Reporting and formats

Prepare and provide monthly cost report and cash flows as required in approved HI formats.

8. QA

Comply with AECOM's quality assurance system.

9. OHS

Comply with AECOM's OHS system.

10. Monthly Cash Flow Forecast

See Appendix A for Monthly fee cash flow forecast

18.3 App 03 - Governance Terms of Reference

CAMPBELLTOWN HOSPITAL REDEVELOPMENT
LEADING MACARTHUR TO BETTER HEALTH

NSW GOVERNMENT Health Infrastructure

Campbelltown Hospital Redevelopment

Project Governance Arrangements

Issue Date: March 2018

Health Infrastructure
NSW GOVERNMENT
Project Governance Arrangements

CONTENTS

Version	Date	Issued To	Status
1,0	18 December 2017	HI	Initial Draft
2.0	18 January 2018	Business Case	Second Draft
3.0	28 March 2018	MoH	For Final Business Case

1 Introduction

The Project Governance Arrangements described in this document align with the responsibilities outlined in the NSW Health Process of Facility Planning (POFP) for Projects above $10m and sets out the standard from which all Project Governance Arrangements shall be derived.

The Project Governance Arrangements also provide mechanisms for project planning and procurement activities in accordance with the Health Infrastructure (HI) Project Delivery Framework and the Treasury Gateway Review Guidelines.

The arrangements cover the Stakeholders and participants including NSW Ministry of Health, Local Health Districts, HI Project Director, and Capital Consultants including the Project Manager.

Tools and references in this document include:

- Project governance structure and summary details
- Terms of Reference (TOR) template for each group including key POFP Roles and Responsibilities in relation to key project deliverables and strategies
- A typical Governance Arrangements Membership matrix

Objectives of the Project Governance Arrangements include to:

- Establish a transparent authority framework to manage Projects
- Provide a clear structure of decision-making and endorsement of key project documents and strategies
- Provide a clear structure of decision-making and endorsement of Project program, budget, and scope
- Provide a coordinated interface between the Project Governance Arrangements and the governance arrangements within the LHD to allow timely decision making regarding clinical and non-clinical inputs to the Project

Each Project will be reviewed and the Project Governance Arrangements developed to reflect the Project scope and specific local requirements prior to establishing the groups and commencing user consultation.

One of the key considerations will be the Local Health District interface and the establishment of project resources and internal decision-making mechanisms early to inform the Project scope and clinical and non-clinical requirements.

2 Process of Facility Planning (POFP)

The Process of Facility Planning for Projects above $10m provides a view of the stakeholder responsibilities related to the planning and implementation of health infrastructure projects in NSW.

HI undertakes its roles and responsibilities as outlined in the POFP in accordance with its delegated powers from the Secretary of NSW Health and the Health Administration Corporation (HAC).

HI appoints Consultant Project Managers for each Project. The responsibilities of the Project Director Planning - PDPl and Project Director Procurement - PDP as outlined in the POFP are carried by HI and its Project Director or the Consultant Project Manager. In this document the responsibilities of the PDPl and PDP have been simply referred to as HI responsibilities.

HI appoints Delivery Contractors (DC) for each Project as outlined in the POFP.

Key Stakeholders with roles and responsibilities within the POFP are:

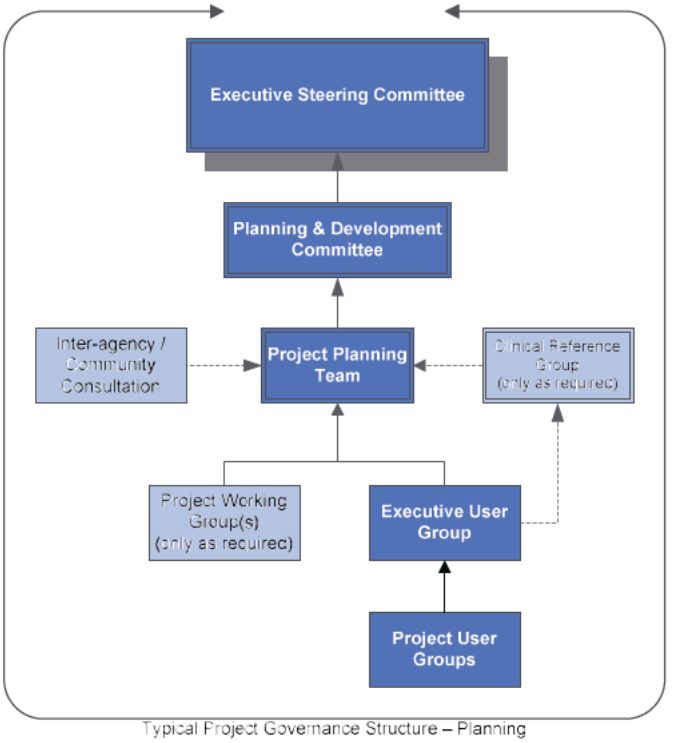
- NSW Treasury

- NSW Health including:
    - Ministry of Health
    - Local Health Districts
    - Health Infrastructure
    - Health Share

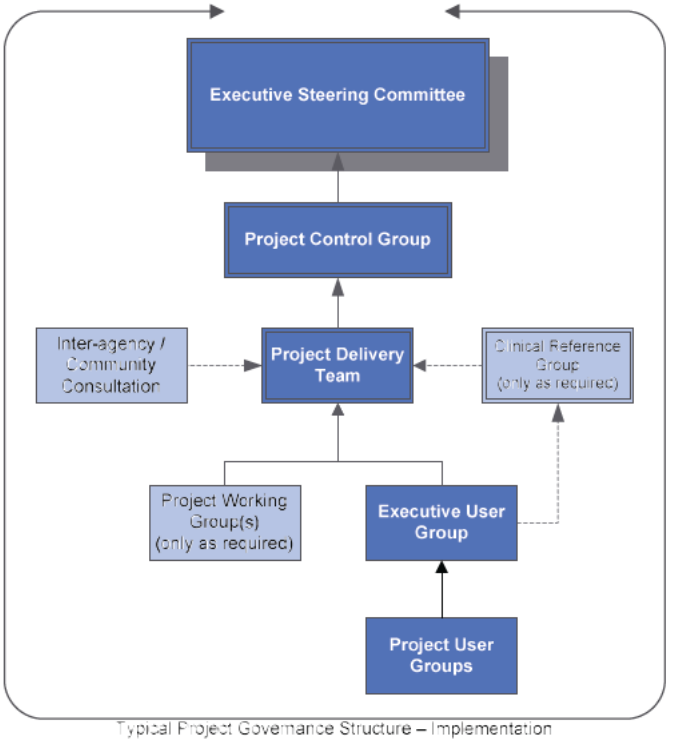
3 Project Governance Structure

The following groups will generally be convened for all Projects.

- Executive Steering Committee (ESC)
- Planning & Development Committee (PDC) (Planning)
- Project Control Group (PCG) (Delivery)
- Project Planning Team (PPT)
- Project Delivery Team (PDT) (Delivery)
- Project Working Group(s) (PWGs)
- Executive User Group (EUG)/Clinical Reference Group (CRG)
- Project User Group(s) (PUGs)



Typical Project Governance Structure – Planning



Typical Project Governance Structure – Implementation

4 Governance Arrangements

To implement the Project Governance Arrangements for a new project the following Terms of Reference summary pages are provided and can be amended and distributed to each group at the start of a Project once local project specific requirements are considered.

4.1 Definition of Terms – Terms of Reference Templates

Within the standard templates for key Project Governance groups the following terms indicate the responsibility level for the groups and Project Stakeholders in relation to key deliverables or key activities as utilised in the POFP.

Informed	Informed about the activity or output
Support	Contribute to / advise on activity or output
Manage	Contractual management responsibility
Endorse	Formal endorsement of activity or output
Responsible	Accountable for the activity or output

The Terms of Reference templates identify key project deliverables and differentiate activities into three components:

1. The responsibility of the project governance groups in relation to completed key project deliverables
2. The role of the group monitoring the development and implementation of the key project deliverable
3. The organisation with the ultimate responsibility for the sign off of the deliverable in accordance with the POFP

See table and examples below.

Example 1	ESC	ESC Monitoring	POFP
Change Management Plan	ESC supports PDC endorsement of the Plan	ESC is informed of status/ key issues associated with development and implementation of the Plan	LHD is accountable for this deliverable and the ongoing implementation.

Example 2	PDC	PDC Monitoring	POFP
Preliminary Business Case, incorporating the requirements of a Service Procurement Plan & Concept Design	PDC endorses Preliminary Business Case for ESC to consider.	PDC supports the development of the Preliminary Business Case.	HI is accountable for this deliverable and the ongoing implementation.

5 Terms of Reference Executive Steering Committee (ESC)

The ESC provides strategic direction and leadership on all Project activities, monitoring achievement of project deliverables (including adherence to Project scope) and endorsing project deliverables prior to submission to HI, MoH or Treasury in the case of Gateway review documentation.

The ESC is the ultimate decision-making authority within the Project Governance structure.

The ESC comprises of delegated executives from those Stakeholders responsible for delivering the Project within the agreed scope. Where issues or variations have been escalated, the ESC will form a recommendation with regard to project scope, budget, or compliance with the Australasian Health Facility Guidelines (AusHFGs) or completion of POFP deliverables for consideration by the Secretary of NSW Health, HI Chief Executive, or the AusHFG Steering Committee.

The ESC is also responsible for providing strategic advice to the Project related to Whole of Government issues and policies.

The ESC shall also provide overall Project direction, strategic advice and leadership; consider political, social or relevant regional commentary around sentiment towards the Project and advice regarding strategic long-term considerations and evaluation of broader redevelopment issues.

Key Project Deliverables and Strategies			
Project Planning – Stage 1 (Parts 0-2)	**ESC**	**ESC Monitoring**	**POFP**
Preliminary Business Case incorporating a Service Procurement Plan and Concept Design	Endorse for LHD and MoH Sign Off	Support	HI
Risk Management Plan	Support	Informed	HI
Financial Impact Statement	Support	Informed	LHD
Economic Appraisal	Support	Informed	HI
Communications and Consultation Strategy	Support	Informed	LHD
Change Management Strategy	Support	Informed	LHD
Options Development	Support	Informed	HI
Workforce Development Strategy	Support	Informed	LHD
Functional Brief including: Models of Care Functional Relationships Operational Policies Workforce Requirements Schedules of Accommodation	Informed of PDC Endorsement	Informed	LHD/HI
Project Planning – Stage 2 (Part 3)	**ESC**	**ESC Monitoring**	**POFP**
Confirmation of Preferred Option	Endorse for HI Sign Off	Support	HI
Final Business Case incorporating a Project Definition Plan and Schematic Design	Endorse for LHD and MoH Sign Off	Support	HI
Variations to AusHFG	Endorse for AusHFG Steering Committee Signoff	Support	HI
Procurement Strategy	Support	Informed	HI

Key Project Deliverables and Strategies			
Financial Impact Statement	Support	Informed	LHD
Economic Appraisal	Support	Informed	HI
Communications and Consultation Plan	Support	Informed	LHD
Change Management Plan	Support	Informed	LHD
Workforce Development Strategy	Support	Informed	LHD
Systems and Equipment including FFE, MME and ICT Strategy	Informed of PDC Endorsement		LHD/HI
Operational Commissioning and Facilities Management Strategy	Support	Informed	LHD
Project Implementation – Stage 3 (Parts 4-9)	**ESC**	**ESC Monitoring**	**POFP**
Procurement Strategy Report and Method	Informed of Sign off by HI	Informed	HI
Developed Design Documentation including Room Data Sheets	Informed of PCG Sign Off	Informed	HI
Tender Documentation	Informed of Sign off by HI	Informed	HI
Request for Tender	Informed	Informed	HI
Variations to Project Scope	Endorse for sign off by MoH	Support	HI
Variations to AusHFG	Endorse for AusHFG Steering Committee Signoff	Support	HI
Tender Evaluation and engagement of preferred tenderer and Award Contract	Informed		HI
Post Tender Review Report to NSW Treasury	Informed		HI
Finalise Design if D&C or DD&C	Informed of PCG Sign Off	Informed	DC
Communications and Consultation Plan	Support	Informed	LHD
Change Management Plan	Support	Informed	LHD
Workforce Development Plan	Support	Informed	LHD
Systems and Equipment including FFE, MME and ICT Strategy	Informed of PCG Endorsement		LHD/HI
Operational Commissioning and Facilities Management Plan	Support	Informed	LHD
Construction Management Plan	Informed	Support	DC
Building Commissioning and Project Completion Plan	Informed of Sign off by HI	Support	DC
Certify Construction Complete	Informed	Support	HI
Handover Facility	Informed	Support	HI
Finalise Operational Commissioning – Move Logistics and Decant Plan	Informed of PCG Endorsement	Support	LHD

Other Project Activities			
All Stages 1, 2 & 3 and Parts 0-9	**ESC**	**ESC Monitoring**	**POFP**
Programme	Endorse	Support	HI
Cost/Budget	Endorse	Support	HI
Gateway Reviews	Informed	Support	HI
Resource Procurement	Informed	Support	HI
Contract Management of Construction	Informed	Support	HI

Standard Membership	Name	Organisation	ESC
HI Chief Executive	Sam Sangster	HI	Member
HI Executive Director Planning & Solutions	David Ballantyne	HI	Invitee
HI Director (Planning or Delivery as relevant)	Steve Hall	HI	(Chair) Member
HI Senior Project Director	Chris Skeggs	HI	Invitee
HI Project Director	Edward Doherty	HI	Invitee
HI Executive Director, Corporate	Erik Maranik	HI	Invitee
HI Consultant Project Manager	Owen Judge	Root Partnerships	Invitee
HI Consultant Project Director	Peter Root	Root Partnerships	Invitee
LHD Chief Executive	Amanda Larkin	SWSLHD	Member
LHD Director, Capital Works, and Infrastructure	David Ryan	SWSLHD	Invitee
General Manager - LHD / Facility	Alison Derrett	Campbelltown Hospital	Invitee
LHD Executive Project Lead / Project Director	Loretta Andersen	Campbelltown Hospital	Invitee
NSW Ministry of Health representative	Cathryn Cox	MoH	Member
NSW Ministry of Health representative	Jacinta George	MoH	Invitee

Quorum

HI CE (Chair) and LHD CE.

Frequency

Minimum quarterly but typically monthly and should be determined on project need.

Support

HI Project Manager Secretariat will record and circulate minutes

Other Notes

- Project ESC meeting shall be co-ordinated for projects greater than $50m in value.
- LHD wide ESC meeting shall be co-ordinated for multiple projects less than $50m in value.
- NSW Treasury to be Members of the ESC for all PPP Projects and Observers on Projects that they consider to be High Risk; confirmation of High Risk should be sought from Treasury on all projects.

6 Terms of Reference Planning & Development Committee (PDC)

During Stage 1 and 2 of the POFP and Parts 0-3 of the Health Infrastructure Project Framework, the PDC is responsible for monitoring and advising on all aspects of the Project, monitoring the achievement of project deliverables for which Stakeholders are responsible as outlined in the POFP (including adherence to Project scope and parameters, making decisions consistent with their level of delegation, providing direction and advice to other governance structures), and endorsing project deliverables prior to submission to the ESC.

The PDC oversees the planning of a Project until Contractor appointment. The key deliverables monitored by the PDC include the Service Procurement Plan (SPP), Preliminary Business Case (PBC), Project Definition Plan (PDP) and the Business Case (BC). The PDC also monitors other key activities such as the development of key strategies such as operational and workforce strategies and change and communication strategies. The PDC monitors overall program and project requirements within budget, time and scope.

Key Project Deliverables and Strategies			
Project Planning – Stage 1 (Parts 0-2)	**PDC**	**PDC Monitoring**	**POFP**
Preliminary Business Case incorporating a Service Procurement Plan and Concept Design	Endorse for ESC to consider	Support	HI
Risk Management Plan	Endorse	Support	HI
Financial Impact Statement	Endorse	Support	LHD
Economic Appraisal	Endorse	Support	HI
Communications and Consultation Strategy	Endorse	Support	LHD
Change Management Strategy	Endorse	Support	LHD
Options Development	Endorse	Support	HI
Workforce Development Strategy	Support	Informed	LHD
Functional Brief including: Models of Care Functional Relationships Operational Policies Workforce Requirements Schedules of Accommodation	Endorse	Support	LHD/HI
Project Planning – Stage 2 (Part 3)	**PDC**	**PDC Monitoring**	**POFP**
Confirmation of Preferred Option	Endorse for ESC to consider	Support	HI
Final Business Case incorporating a Project Definition Plan and Schematic Design	Endorse for ESC to consider	Support	HI
Risk Management Plan	Endorse	Support	HI
Variations to AusHFG	Endorse for ESC to consider	Support	HI
Procurement Strategy	Informed	Informed	HI
Financial Impact Statement	Endorse	Support	LHD
Economic Appraisal	Endorse	Support	HI

Key Project Deliverables and Strategies			
Communications and Consultation Plan	Endorse	Support	LHD
Change Management Plan	Endorse	Support	LHD
Workforce Development Plan	Support	Informed	LHD
Systems and Equipment including FFE, MME and ICT Strategy	Endorse	Informed	LHD
Operational Commissioning and Facilities Management Strategy	Endorse	Support	LHD

Other Project Activities			
All Stages 1, 2 & 3 and Parts 0-3	**PDC**	**PDC Monitoring**	**POFP**
Programme	Endorse for ESC to consider	Support	HI
Cost/Budget	Endorse for ESC to consider	Support	HI
Gateway Reviews	Informed	Support	HI
Resource Procurement	Informed	Informed	HI

Standard Membership	Name	Organisation	PDC
HI Director Planning	Steve Hall	HI	Chair Member
HI Project Director	Edward Doherty	HI	Invitee
HI Consultant Project Manager	Owen Judge	Root Partnerships	Invitee
HI Consultant Project Manager	Meegan Babe	Root Partnerships	Invitee
Architect (Consultant)	Tara Veldman	BLP	Invitee
Cost Manager	Gary Train	Aecom	Invitee
LHD Chief Executive	Amanda Larkin	SWLHD	Member
General Manager - LHD / Facility	Alison Derrett	Campbelltown Hospital	Member
LHD Executive / representative	Loretta Andersen	Campbelltown Hospital	Member
EUG and/or CRG Chairs	Deanna Aplitt	Campbelltown Hospital	Member
Clinical leaders / representatives	Various		Member
Non-clinical / representative	Various		Member
Communications representative (LHD)	Clare Searson	SWSLHD	Invitee
WSU Dean, School of Medicine	Ann Marie Hennessey	SWSLHD	Invitee

Quorum

Chair and 50% of members.

Frequency

Monthly or as determined based on project need.

Support

HI Consultant Project Manager Secretariat will record and circulate minutes.

7 Terms of Reference Project Control Group (PCG)

On completion of the Stage 2 of the POFP and Part 3 of the Health Infrastructure Project Delivery Framework the PDC is replaced by the Project Control Group (PCG). The PCG takes on the responsibility of managing the key deliverables and key activities for the Project scope as defined by the PDP/BC through Stage 3 of the POFP and Parts 4-9 of the Health Infrastructure Project Delivery Framework.

During implementation the PCG is responsible for overseeing construction and commissioning, providing direction and advice to other governance structures, monitoring and reporting to the ESC on project progress and making decisions consistent with their level of delegation.

The key deliverables monitored by the PCG include procurement methodology, design development documentation, tender documentation and variations. The PCG also monitors the implementation of other key strategies and activities such as change and communication strategies and operation and commissioning planning.

Key Project Deliverables and Strategies			
Project Implementation – Stage 3 (Parts 4-9)	**PCG**	**PCG Monitoring**	**POFP**
Procurement Strategy Report and Method	Informed	Support	HI
Developed Design Documentation including Room Data Sheets – consistent with intent of Schematic Design	Informed of PUG and EUG Sign Off	Support	HI
Tender Documentation	Informed of HI Sign Off	Informed	HI
Request for Tender	Informed	Informed	HI
Variations to approved Project Scope	Endorse for ESC to consider	Support	HI
Variations to AusHFG	Endorse for ESC to consider	Support	
Tender Evaluation and engagement of preferred tenderer and Award Contract	Informed		HI
Post Tender Review Report to NSW Treasury	Informed		HI
Finalise Design if D&C or DD&C	Endorse	Support	DC
Communications and Consultation Strategy	Endorse	Support	LHD
Change Management Strategy	Endorse	Support	LHD
Workforce Development Strategy	Support	Informed	LHD
Systems and Equipment including FFE, MME and ICT Strategy	Endorse	Support	LHD
Operational Commissioning and Facilities Management Strategy	Endorse	Support	LHD
Construction Management Plan	Informed	Support	LHD
Building Commissioning and Project Completion Plan	Endorse for HI Sign Off	Support	DC
Certify Construction Complete	Informed	Support	DC

Key Project Deliverables and Strategies			
Handover Facility	Informed	Support	HI
Finalise Operational Commissioning – Move Logistics and Decant Plan	Endorse	Support	HI

Other Project Activities			
Stage 3 and Parts 4-9	**PCG**	**PCG Monitoring**	**POFP**
Programme	Endorse for ESC to consider	Support	HI
Cost/Budget	Endorse for ESC to consider	Support	HI
Gateway Reviews	Informed	Support	HI
Resource Procurement	Informed	Support	HI

Standard Membership	Name	Organisation	PCG
HI Director Delivery	Steve Hall	HI	Member
HI Project Director	Edward Doherty	HI	Chair (Member)
HI Consultant Project Manager	Owen Judge	Root Partnerships	Invited
Architect (Consultant)	Tara Veldman	BLP	Invited
Cost Manager	Gary Train	Aecom	Invited
LHD Chief Executive	Amanda Larkin	SWLHD	Invited
General Manager - LHD / Facility	Alison Derrett	Campbelltown Hospital	Member
LHD Executive / representative	Loretta Anderson	Campbelltown Hospital	Member
EUG and/or CRG Chairs	Deanna Aplitt	Campbelltown Hospital	Member
Communications representative (LHD)	Clare Searson	SWSLHD	Invited
Change Management representative	Amy Coghill	Campbelltown Hospital	Invited
NSW Ministry of Health representative(s)	Cathryn Cox Jacinta George	MoH MoH	Member
Consumer representative(s) if required	Various		Invited

Quorum

Chair and 50% of members.

Frequency

Monthly or as determined based on project need.

Support

HI Consultant Project Manager Secretariat will record and circulate minutes.

8 Terms of Reference Project Planning Team (PPT)

The PPT is responsible for early planning for operational planning and implementation to facilitate the achievement of Project objectives as defined the SPP/PBC and subsequently the PDP/BC. The role of the PPT includes the interface with Project Working Groups (PWGs), Project User Groups (PUGs), and monitoring and/or implementing key operational and clinical strategies which support the POFP including risk management, change management (including operational policies and models of care), communications, operation and commissioning (including non-clinical support services, systems and equipment)

The PPT is responsible for the consideration and coordination of the consultation processes and engagement with users. The PPT reviews key activities and provides advice to the PWGs, EUG, PUGs and PDC/PCG on clinical and non-clinical issues in order to facilitate, co-ordinate, guide and advise the project as required.

Key Project Deliverables and Strategies			
Project Planning – Stage 1 (Parts 0-2)	**PPT**	**PPT Monitoring**	**POFP**
Preliminary Business Case incorporating a Service Procurement Plan and Concept Design	Endorse relevant parts for PDC to consider	Support	HI
Compliance with policy and planning framework	Endorse relevant parts for PDC to consider	Support	LHD
Risk Management Plan	Endorse for relevant parts for PDC to consider	Support	HI
Financial Impact Statement	Endorse relevant parts for PDC to consider	Support	LHD
Economic Appraisal	Support with relevant information	Informed	HI
Communications and Consultation Strategy	Endorse for PDC to consider	Support	LHD
Change Management Strategy	Endorse for PDC to consider	Support	LHD
Options Development	Support with relevant information	Informed	HI
Workforce Development Strategy	Endorse	Support	LHD
Functional Brief including: Models of Care Functional Relationships Operational Policies Workforce Requirements Schedules of Accommodation	Endorse for PDC to consider	Support	LHD/HI
Project Planning – Stage 2 (Part 3)	**PPT**	**PPT Monitoring**	**POFP**
Confirmation of Preferred Option	Informed of PDC and ESC endorsement		
Final Business Case incorporating a Project Definition Plan and Schematic Design	Endorse relevant parts for PDC to consider	Support	HI
Compliance with policy and planning framework	Endorse	Support	LHD

Key Project Deliverables and Strategies			
Risk Management Plan	Endorse relevant parts for PDC to consider	Support	HI
Variations to AusHFG	Support with identification of Variations	Informed	HI
Procurement Strategy	Informed		HI
Financial Impact Statement	Endorse relevant parts for PDC to consider	Support	LHD
Economic Appraisal	Support with relevant information	Informed	HI
Communications and Consultation Plan	Endorse for PDC to consider	Support	LHD
Change Management Plan	Endorse for PDC to consider	Support	LHD
Workforce Development Strategy	Endorse	Support	LHD
Systems and Equipment including FFE, MME, ICT Strategy	Endorse the Clinical Requirements of ICT, FFE and MME	Support	LHD
Operational Commissioning and Facilities Management Strategy	Support with relevant information	Informed	LHD

Standard Membership	Name	Organisation	PPT
HI Project Director	Steve Hall	HI	Invited
HI Consultant Project Manager	Owen Judge	Root Partnerships	Member
Architect (Consultant)	Tara Veldman	BLP	Invited
General Manager – Health Service / Facility	Alison Derrett	Campbelltown Hospital	Chair (Member)
LHD Executive / representative	Loretta Anderson	Campbelltown Hospital	Member
LHD Service Planning representative (Stage 1 and 2)	Simone Proft & Alison Tidbury	SWSLHD	Member
Clinical leaders / representatives	Various		Member
Non-clinical / representative	Various		Member
Communications representative (LHD)	Clare Searson	SWSLHD	Invited
Change management representative (LHD)	To Be Appointed Jan 2018	SWSLHD	Invited

Quorum

Chair and 50% of members.

Frequency

Monthly or as determined based on project need.

Support

HI Consultant Project Manager Secretariat will record and circulate minutes.

9 Terms of Reference Project Delivery Team (PDT)

The PDT is responsible for operational planning and implementation to facilitate the achievement of project objectives as defined the SPP/PBC and subsequently the PDP/BC during the delivery of the project. The role of the PDT includes the interface with Project Working Groups (PWGs), Project User Groups (PUGs), and monitoring and/or implementing key strategies which support the POFP including risk management, change management (including operational policies and models of care), communications, operation and commissioning (including non-clinical support services, systems and equipment).

The PDT is responsible for the consideration and coordination of the consultation processes and engagement with Users. The PDT reviews key activities and provides advice to the PWGs, PUGs and PDC/PCG on clinical and non-clinical issues in order to facilitate, co-ordinate, guide and advise the project as required.

Key Project Deliverables and Strategies			
Project Implementation – Stage 3 (Parts 4-9)	**PDT**	**PDT Monitoring**	**POFP**
Procurement Strategy Report and Method	Informed		HI
Developed Design Documentation including Room Data Sheets – consistent with intent of Schematic Design	Endorse relevant parts for PDC to consider	Support	HI
Tender Documentation	Informed		HI
Request for Tender	Informed		HI
Variations to approved Project Scope	Informed		HI
Variations to AusHFG	Support with identification of Variations		HI
Tender Evaluation and engagement of preferred tenderer and Award Contract	Informed		HI
Post Tender Review Report to NSW Treasury	Informed		HI
Finalise Design if D&C or DD&C	Endorse relevant parts for PCG to consider	Support	HI
Communications and Consultation Strategy	Endorse relevant parts for PCG to consider	Support	DC
Change Management Plan	Support with relevant information		HI
Workforce Development Plan	Support with relevant information		LHD
Systems and Equipment including FFE, MME and ICT Strategy	Support with relevant information		LHD
Operational Commissioning and Facilities Management Strategy	Support with relevant information		LHD
Construction Management Plan	Support with relevant information		DC

Key Project Deliverables and Strategies			
Project Implementation – Stage 3 (Parts 4-9)	**PDT**	**PDT Monitoring**	**POFP**
Building Commissioning and Project Completion Plan	Support with relevant information		DC
Certify Construction Complete	Informed		HI
Handover Facility	Informed		HI
Finalise Operational Commissioning – Move Logistics and Decant Plan	Informed		LHD

Standard Membership	Name	Organisation	ESC
HI Project Director	Steve Hall	HI	Invited
HI Consultant Project Manager	Owen Judge	Root Partnerships	Invited
Architect (Consultant)	Tara Veldman	BLP	Invited
General Manager – Health Service / Facility	Alison Derrett	Campbelltown Carpark	Chair (Member)
LHD Executive / representative	Loretta Anderson	Campbelltown	Member
Clinical leaders / representatives	Various		Member
Non-clinical personnel / operational managers	Various		Member
Communications representative (LHD)	Clare Searson	SWSLHD	Invited
Change Management representative (LHD)	Amy Coghill	SWSLHD	Invited

Support

HI Consultant Project Manager Secretariat will record and circulate minutes.

10 Terms of Reference Project Working Group(s) (PWGs)

PWGs report to the PPT and PDT depending on the stage of the Project and have responsibility for developing monitoring key project activities including communications and consultation, change management, overarching operational policy development, capital and recurrent cost estimates and economic appraisals. They are convened as required to coordinate, monitor and implement planning strategies to achieve project objectives and timeframes. In particular the groups are responsible for planning requirements with whole-of-organisation impacts. The type and number of PWGs will be developed in accordance to the needs of the Project and to address issues that are complex and require resolution or require co-ordination across clinical or functional areas within the facility or LHD.

Typical Working Groups may include:

- FFE Control Group
- Communications and Consultation
- Change Management
- ICT Strategy
- Commissioning and Operational Planning
- Systems and Equipment – Major Medical
- Move Logistics and Decant

Standard Membership	Name	Organisation	ESC
HI Consultant Project Manager (Consultant)	Owen Judge	HI	Invited
General Manager – Health Service / Facility	Alison Derrett	Campbelltown Hospital	Invited
LHD Executive / representative *	Loretta Anderson	Campbelltown Hospital	Chair (Member)
Clinical leaders / representatives	Various		Member
Change Management representative (LHD)	Amy Coghill	SWSLHD	Invited
Non-clinical personnel / operational managers	Various		Member
Consumer representative(s) if required	Various		Invited

Quorum

Chair and 50% of members.

Frequency

As determined based on User Consultation programme.

Support

LHD representatives will provide secretariat support and will record and circulate minutes.

* Where LHD Executive is not in attendance the role of Chair will be delegated to relevant clinical or non-clinical representative

11 Terms of Reference Clinical Reference Group (CRG)

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

12 Terms of Reference Executive User Group (EUG)

The EUG is responsible for overseeing the PUG process. This includes resolving issues escalated from PUGs and ensuring consistency across each PUG and alignment with design briefs with Clinical Services Plan (CSP), local, area and state-wide, LHD and Facility operational policies and other project parameters. The EUG is also responsible for endorsing design briefs and design documents prior to submission to the PPT or PDT for endorsement.

Key Project Deliverables and Strategies			
Project Planning – Stage 1 (Parts 0-2)	**EUG/CRG**	**EUG/CRG Monitoring**	**POFP**
Preliminary Business Case incorporating a Service Procurement Plan and Concept Design	Endorse relevant information	Support PUGs with resolution of issues	HI
Change Management Strategy	Support with relevant information		LHD
Options Development	Support with relevant information		HI
Workforce Development Strategy	Support with relevant information		LHD
Functional Brief including: Models of Care Functional Relationships Operational Policies Workforce Requirements Schedules of Accommodation	Support with relevant information	Informed regarding work of PUGs	HI
Project Planning – Stage 2 (Part 3)	**EUG/CRG**	**EUG/CRG Monitoring**	**POFP**
Confirmation of Preferred Option	Informed		
Final Business Case incorporating a Project Definition Plan and Schematic Design	Endorse relevant information	Support PUGs with resolution of issues	HI
Compliance with policy and planning framework	Support with relevant information	Informed regarding work of PUGs	LHD
Variations to AusHFG	Support with identification of Variations	Informed regarding work of PUGs	HI
Change Management Plan	Support with relevant information	Informed regarding work of PUGs and PWGs	LHD
Workforce Development Plan	Support with relevant information	Informed regarding work of PUGs	LHD
Systems and Equipment including FFE, MME and ICT Strategy	Support with relevant information	Informed regarding work of PUGs and PWGs	LHD

Key Project Deliverables and Strategies			
Operational Commissioning and Facilities Management Strategy	Support with relevant information	Informed regarding work of PUGs and PWGs	LHD
Project Implementation – Stage 3 (Parts 4-9)	**EUG/CRG**	**EUG/CRG Monitoring**	**POFP**
Developed Design Documentation including Room Data Sheets – consistent with intent of Schematic Design	Endorse relevant parts for PDT to consider	Support with relevant information	HI
Tender Documentation	Informed		HI
Request for Tender	Informed		HI
Variations to approved Project Scope	Informed		HI
Tender Evaluation and engagement of preferred tenderer and Award Contract	Informed		HI
Post Tender Review Report to NSW Treasury	Informed		HI
Finalise Design if D&C or DD&C	Endorse relevant parts for PDT to consider	Support	DC
Change Management Strategy	Support with relevant information	Informed regarding work of PUGs and PWGs	LHD
Workforce Development Strategy	Support with relevant information	Informed regarding work of PUGs	LHD
Systems and Equipment including FFE, MME and ICT Technology Strategy	Support with relevant information	Informed regarding work of PUGs	LHD
Operational Commissioning and Facilities Management Strategy	Support with relevant information	Informed regarding work of PUGs and PWGs	LHD
Construction Management Plan	Support with relevant information	Informed	DC
Building Commissioning and Project Completion Plan	Support with relevant information	Informed	DC
Finalise Operational Commissioning – Move Logistics and Decant Plan	**Support with relevant information**	**Informed regarding work of PUGs and PWGs**	**LHD**

Standard Membership	Name	Organisation	EUG/CRG
HI Project Director	Steve Hall	HI	Invited
HI Consultant Project Manager	Owen Judge	Root Partnerships	Invited
Architect (Consultant)	Tara Veldman	BLP	Invited
General Manager - LHD / Facility	Alison Derrett	Campbelltown Hospital	Chair
LHD Executive Director Sponsor	David Ryan	SWSLHD	Invitee
LHD Director of Operations	Clair Ramsden	Campbelltown Hospital	Invitee
LHD Executive Project Lead / Project Director	Loretta Andersen	Campbelltown Hospital	Invitee
LHD of Corporate Service	Deanna Aplitt	Campbelltown Hospital	Invitee
Clinical leaders / representatives	Dr Paul Chay	SWSLHD	Invitee
Clinical leaders / representatives	Dr Claire Jones	SWSLHD	Invitee
Clinical leaders / representatives	Prof Sellappa Prahalath	Campbelltown Hospital	Invitee
Clinical leaders / representatives	Karen Kenmir	Campbelltown Hospital	Invitee
Clinical leaders / representatives	Brian Lane	Campbelltown Hospital	Invitee
Clinical leaders / representatives	Prof Brad Frankum	Campbelltown Hospital	Invitee
Clinical leaders / representatives	Dr Raymond Chin	Campbelltown Hospital	Invitee
Clinical leaders / representatives	Dr Deepak Bhonagiri	Campbelltown Hospital	Invitee
Clinical leaders / representatives	Prof Richard Cracknell	Campbelltown Hospital	Invitee
Clinical leaders / representatives	Tuan- Anh Nguyen	Campbelltown Hospital	Invitee
Clinical leaders / representatives	Prof Friedbert Kohler	Campbelltown Hospital	Invitee
Clinical leaders / representatives	Prof Geoff Delaney	Campbelltown Hospital	Invitee
Clinical leaders / representatives	Prof Rohan Rajaratnam	Campbelltown Hospital	Invitee
Clinical leaders / representatives	Dr Alan McDougall	Campbelltown Hospital	Invitee
Clinical leaders / representatives	Prof Les Bokey	Campbelltown Hospital	Invitee
Clinical leaders / representatives	Dr Peter Lin	Campbelltown Hospital	Invitee
Clinical leaders / representatives	John Smoleniec	Campbelltown Hospital	Invitee
Clinical leaders / representatives	Prof Neil Merrett	Campbelltown Hospital	Invitee
Clinical leaders / representatives	Dr Michael Kernohan	Campbelltown Hospital	Invitee
Clinical leaders / representatives	Dr Jing Song	Campbelltown Hospital	Invitee
Clinical leaders / representatives	Dr Upul Premawardhana	Campbelltown Hospital	Invitee
Clinical leaders / representatives	Dr Sacha Kobilski	Campbelltown Hospital	Invitee
Clinical leaders / representatives	Dr Kevin Pile	Campbelltown Hospital	Invitee
Clinical leaders / representatives	Dr Mohammad Ilyas	Campbelltown Hospital	Invitee
Clinical leaders / representatives	Patricia Mason	Campbelltown Hospital	Invitee
Clinical leaders / representatives	Prof Stephen Della-Fiorentina	Campbelltown Hospital	Invitee

Clinical leaders / representatives	Dr Lynne Kuwahata	Campbelltown Hospital	Invitee
LHD Operational Managers	Nathan Jones	Campbelltown Hospital	Invitee
Clinical leaders / representatives	Meagan Elder	Campbelltown Hospital	Invitee
LHD Operational Managers	Simone Proft	SWSLHD	Member
LHD Operational Managers	Alison Tidbury	SWSLHD	Invited
LHD Operational Managers	Robynne Cooke	SWSLHD	Invitee
LHD Operational Managers	Prof Josephine Chow	SWSLHD	Invitee
LHD Operational Managers	Dr Annette Tognela	SWSLHD	Invitee
NSW Ministry of Health representative as required	Cathryn Cox	MoH	Invited

Quorum

Chair and 50% of members

Frequency

As determined based on project need

Support

HI Consultant Project Manager Secretariat will record and circulate minutes.

13 Terms of Reference Project User Group(s) (PUGs)

PUGs report to the EUG as required and refer clinical matters for resolution to the CRG. PUGs are responsible for developing the functional briefs for health planning units (HPUs). A key requirement is to ensure these briefs are aligned with the endorsed CSP, local, area and statewide operational policies and other Project parameters.

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

Key Project Deliverables and Strategies			
Project Planning – Stages 1 & 2 (Parts 2 & 3)	**PUG**	**PUG Monitoring**	**POFP**
Confirmation of Preferred Option	Informed		
Final Business Case incorporating a Project Definition Plan and Schematic Design	Endorse relevant information for HPU consideration by EUG/CRG	Support with relevant information	HI
Compliance with policy and planning framework	Support with relevant information	Informed by policies	LHD
Variations to AusHFG	Support with identification of Variations		HI
Change Management Strategy	Support with relevant information		LHD
Workforce Development Strategy	Support with relevant information		LHD
Systems and Equipment including FFE, MME and ICT Strategy	Support with relevant information		LHD
Operational Commissioning and Facilities Management Strategy	Support with relevant information		LHD
Functional Brief including: Models of Care Functional Relationships Operational Policies Workforce Requirements Schedules of Accommodation	Support with relevant information		LHD/ HI
Project Implementation – Stage 3 (Parts 4-9)	**PUG**	**PUG Monitoring**	**POFP**
Developed Design Documentation including Room Data Sheets – consistent with intent of Schematic Design	Endorse relevant parts for EUG/CRG to consider	Support with relevant information	PDPr
Tender Documentation	Informed		PDPr
Request for Tender	Informed		HI
Variations to approved Project Scope	Informed		HI
Tender Evaluation and engagement of preferred tenderer and Award Contract	Informed		HI
Finalise Design if D&C or DD&C	Endorse relevant parts for EUG/CRG to consider	Support	DC

Key Project Deliverables and Strategies			
Change Management Strategy	Support with relevant information		LHD
Workforce Development Strategy	Support with relevant information		LHD
Systems and Equipment including FFE, MME & ICT Strategy	Support with relevant information		LHD
Operational Commissioning and Facilities Management Strategy	Support with relevant information		LHD
Construction Management Plan	Support with relevant information		DC
Building Commissioning and Project Completion Plan	Support with relevant information		DC
Finalise Operational Commissioning – Move Logistics and Decant Plan	Support with relevant information		LHD

Standard Membership	Name	Organisation	PUG
HI Project Director	Steve Hall	HI	Invitee
HI Consultant Project Manager	Owen Judge	Root Partnerships	Invitee
LHD Executive / representative	Alison Derrett	Campbelltown Hospital	Invitee
LHD Executive / representative	Loretta Andersen	Campbelltown Hospital	Invitee
Clinical leaders / representatives	Prof Neil Merrett	Campbelltown Hospital	Invitee
Clinical leaders / representatives	Prof Richard Cracknell	Campbelltown Hospital	Invitee
Clinical leaders / representatives	Tuan- Anh Nguyen	Campbelltown Hospital	Invitee
Clinical leaders / representatives	Dr Deepak Bhonagiri	Campbelltown Hospital	Invitee
Clinical leaders / representatives	Dr Ian Turner	Campbelltown Hospital	Invitee
Clinical leaders / representatives	Tracey Worthington	Campbelltown Hospital	Invitee
Clinical leaders / representatives	Dr Jing Song	Campbelltown Hospital	Invitee
Clinical leaders / representatives	Tatanya Simmonds	Campbelltown Hospital	Invitee
Clinical leaders / representatives	Prof Kevin Pile	Campbelltown Hospital	Invitee
Clinical leaders / representatives	Dr Raymond Chin	Campbelltown Hospital	Invitee
Clinical leaders / representatives	Dr Karuna Keat	Campbelltown Hospital	Invitee
Clinical leaders / representatives	Dr Gary Flynn	Campbelltown Hospital	Invitee
Clinical leaders / representatives	Dr Sacha Kobilski	Campbelltown Hospital	Invitee
Clinical leaders / representatives	Dr Catherine Allgood	Campbelltown Hospital	Invitee
Clinical leaders / representatives	Fiona Tilson	Campbelltown Hospital	Invitee
Clinical leaders / representatives	Prof Stephen Della-Fiorentina	Campbelltown Hospital	Invitee
Clinical leaders / representatives	Prof Annemarie Hennessy	Campbelltown Hospital	Invitee
Clinical leaders / representatives	Karen Kenmir	Campbelltown Hospital	Invitee
Clinical Consultants representative	Adrian Shea	Carramar Consultants	Invitee

Clinical Consultants representative	Elizabeth Hewitt-Falls	Carramar Consultants	Invitee
Clinical Consultants representative	Sue McKee	Carramar Consultants	Invitee
Clinical Consultants representative	Peter Frew	Carramar Consultants	Invitee
Clinical Consultants representative	Nataliya Daniel	Carramar Consultants	Invitee
Clinical Consultants representative	Zhicheng Li	Carramar Consultants	Invitee
Clinical Consultants representative	Raphael Rutkowski	Carramar Consultants	Invitee
Clinical Consultants representative	Jenny Sheehan	Carramar Consultants	Invitee

Quorum

Chair and 50% of members

Frequency

As determined based User Consultation programme

Support

HI Consultant Project Manager will record and circulate minutes (functional brief)

Architect secretariat will record and circulate minutes (design)

List of Attachments

1. Project Governance Arrangements Typical Memberships

Attachment 1: Project Governance Arrangements Typical Memberships

Standard Membership	Name	Organisation	ESC	PDC	PCG	PPT	PDT	PWGs	EUG /CRG	PUGs
HI Chief Executive	Sam Sangster	HI	Member	-	n/a	n/a	n/a	n/a	-	-
HI Director	David Ballantyne	HI	Invitee	-	n/a	n/a	n/a	n/a	-	-
HI Project Director	Steve Hall	HI	Invitee	Chair	n/a	n/a	n/a	n/a	Invitee	Invitee
HI Consultant Project Manager	Owen Judge	Root Partnerships	Invitee	Invitee	n/a	n/a	n/a	n/a	Invitee	Invitee
Architect (Consultant)	Tara Veldman	BLP	-	Invitee	n/a	n/a	n/a	n/a	Invitee	-
Cost Manager	Gary Train	AECOM		Invitee	n/a	n/a	n/a	n/a	Invitee	-
LHD Chief Executive	Amanda Larkin	LHD	Member	Invitee	n/a	n/a	n/a	n/a	-	-
General Manager - LHD / Facility	Alison Derrett	LHD	Invitee	Invitee	n/a	n/a	n/a	n/a	Invitee	Invitee
LHD – Executive Director Sponsor	David Ryan	LHD	Invitee	Invitee	n/a	n/a	n/a	n/a	Invitee	Invitee
LHD Executive / representative	Loretta Andersen	LHD	Invitee	Invitee	n/a	n/a	n/a	n/a	Invitee	Invitee
LHD Service Planning Representative (Stages 1 and 2)	Simone Proft	LHD	-	-	n/a	n/a	n/a	n/a	Invitee	Invitee
Clinical leaders / representatives	Prof Brad Frankum	Campbelltown Hospital	-	Invitee	n/a	n/a	n/a	n/a	Invitee	Invitee
Clinical leaders / representatives	Dr Raymond Chin	Campbelltown Hospital	-	Invitee	n/a	n/a	n/a	n/a	Invitee	Invitee
Clinical leaders / representatives	Dr Deepak Bhonagiri	Campbelltown Hospital	-	Invitee	n/a	n/a	n/a	n/a	Invitee	Invitee
Clinical leaders / representatives	Prof Richard Cracknell	Campbelltown Hospital	-	Invitee	n/a	n/a	n/a	n/a	Invitee	Invitee

Clinical leaders / representatives	Scott Metcalfe	Campbelltown Hospital	Invitee	-	n/a	n/a	n/a	n/a	Invitee	Invitee
Clinical leaders / representatives	Dr Paul Chay	Campbelltown Hospital	-	-	n/a	n/a	n/a	n/a	Invitee	Invitee
Clinical leaders / representatives	Dr Claire Jones	Campbelltown Hospital	-	-	n/a	n/a	n/a	n/a	Invitee	Invitee
Clinical leaders / representatives	Prof Sellappa Prahalath	Campbelltown Hospital	-	-	n/a	n/a	n/a	n/a	Invitee	Invitee
Clinical leaders / representatives	Karen Kenmir	Campbelltown Hospital	-	-	n/a	n/a	n/a	n/a	Invitee	Invitee
Clinical leaders / representatives	Brian Lane	Campbelltown Hospital	-	-	n/a	n/a	n/a	n/a	Invitee	Invitee
Clinical leaders / representatives	Tuan- Anh Nguyen	Campbelltown Hospital	-	-	n/a	n/a	n/a	n/a	Invitee	Invitee
Clinical leaders / representatives	Prof Friedbert Kohler	Campbelltown Hospital	-	-	n/a	n/a	n/a	n/a	Invitee	Invitee
Clinical leaders / representatives	Prof Rohan Rajaratnam	Campbelltown Hospital	-	-	n/a	n/a	n/a	n/a	Invitee	Invitee
Clinical leaders / representatives	Dr Alan McDougall	Campbelltown Hospital	-	-	n/a	n/a	n/a	n/a	Invitee	Invitee
Clinical leaders / representatives	Prof Les Bokey	Campbelltown Hospital	-	-	n/a	n/a	n/a	n/a	Invitee	Invitee
Clinical leaders / representatives	Dr Peter Lin	Campbelltown Hospital	-	-	n/a	n/a	n/a	n/a	Invitee	Invitee
Clinical leaders / representatives	John Smoleniec	Campbelltown Hospital	-	-	n/a	n/a	n/a	n/a	Invitee	Invitee

Clinical leaders / representatives	Prof Neil Merrett	Campbelltown Hospital	-	-	n/a	n/a	n/a	n/a	Invitee	Invitee
Clinical leaders / representatives	Dr Michael Kernohan	Campbelltown Hospital	-	-	n/a	n/a	n/a	n/a	Invitee	Invitee
Clinical leaders / representatives	Dr Jing Song	Campbelltown Hospital	-	-	n/a	n/a	n/a	n/a	Invitee	Invitee
Clinical leaders / representatives	Dr Upul Premawardhana	Campbelltown Hospital	-	-	n/a	n/a	n/a	n/a	Invitee	Invitee
Clinical leaders / representatives	Dr Sacha Kobilski	Campbelltown Hospital	-	-	n/a	n/a	n/a	n/a	Invitee	Invitee
Clinical leaders / representatives	Dr Kevin Pile	Campbelltown Hospital	-	-	n/a	n/a	n/a	n/a	Invitee	Invitee
Clinical leaders / representatives	Dr Mohammad Ilyas	Campbelltown Hospital	-	-	n/a	n/a	n/a	n/a	Invitee	Invitee
Clinical leaders / representatives	Patricia Mason	Campbelltown Hospital	-	-	n/a	n/a	n/a	n/a	Invitee	Invitee
Clinical leaders / representatives	Prof Stephen Della-Fiorentina	Campbelltown Hospital	-	-	n/a	n/a	n/a	n/a	Invitee	Invitee
Clinical leaders / representatives	Dr Ian Turner	Campbelltown Hospital	-	-	n/a	n/a	n/a	n/a	-	Invitee
Clinical leaders / representatives	Tracey Worthington	Campbelltown Hospital	-	-	n/a	n/a	n/a	n/a	-	Invitee
Clinical leaders / representatives	Dr Karuna Keat	Campbelltown Hospital	-	-	n/a	n/a	n/a	n/a	-	Invitee
Clinical leaders / representatives	Dr Gary Flynn	Campbelltown Hospital	-	-	n/a	n/a	n/a	n/a	-	Invitee

Clinical leaders / representatives	Dr Sacha Kobilski	Campbelltown Hospital	-	-	n/a	n/a	n/a	n/a	-	Invitee
Clinical leaders / representatives	Dr Catherine Allgood	Campbelltown Hospital	-	-	n/a	n/a	n/a	n/a	-	Invitee
Clinical leaders / representatives	Fiona Tilson	Campbelltown Hospital	-	-	n/a	n/a	n/a	n/a	-	Invitee
Clinical leaders / representatives	Prof Annemarie Hennessy	Campbelltown Hospital	-	-	n/a	n/a	n/a	n/a	-	Invitee
Clinical leaders / representatives	Karen Kenmir	Campbelltown Hospital	-	-	n/a	n/a	n/a	n/a	-	Invitee
Clinical Consultants	Adrian Shea	Carramar Consultants	-	-	n/a	n/a	n/a	n/a	-	Invitee
Clinical Consultants	Elizabeth Hewitt-Falls	Carramar Consultants	-	-	n/a	n/a	n/a	n/a	Invitee	Invitee
Clinical Consultants	Sue McKee	Carramar Consultants	-	-	n/a	n/a	n/a	n/a	-	Invitee
Clinical Consultants	Peter Frew	Carramar Consultants	-	-	n/a	n/a	n/a	n/a	-	Invitee
Clinical Consultants	Nataliya Daniel	Carramar Consultants	-	-	n/a	n/a	n/a	n/a	Invitee	Invitee
Clinical Consultants	Zhicheng Li	Carramar Consultants	-	-	n/a	n/a	n/a	n/a	-	Invitee
Clinical Consultants	Raphael Rutkowski	Carramar Consultants	-	-	n/a	n/a	n/a	n/a	-	Invitee
Clinical Consultants	Jenny Sheehan	Carramar Consultants	-	-	n/a	n/a	n/a	n/a	Invitee	Invitee
LHD Operational Managers	Clair Ramsden	LHD	-	-	n/a	n/a	n/a	n/a	Invitee	-

LHD Operational Managers	Deanna Aplitt	LHD	-	-	n/a	n/a	n/a	n/a	Invitee	Invitee
LHD Operational Managers	Nathan Jones	LHD	-	-	n/a	n/a	n/a	n/a	Invitee	-
LHD Operational Managers	Meagan Elder	LHD	-	-	n/a	n/a	n/a	n/a	Invitee	Invitee
NSW Ministry of Health representative(s)	Jacinta George	MoH	Invitee	Invitee	n/a	n/a	n/a	n/a	Invitee	-
NSW Ministry of Health representative(s)	Cathryn Cox	MoH	Member	Member	n/a	n/a	n/a	n/a	Invitee	-

18.4 App 04 – Consultant Procurement

The status of consultant appointments and scope of service is shown in the table below.

Discipline	Consultancy	Current Scope	Status
Project Manager	Root Partnerships	Stage 2 Part 0 – 3, and MSCP	Appointed
Cost Manager	AECOM	MSCP and Stage 2 scope to Part 3	Appointed
Architect	Billard Leece Partnership (BLP)	MSCP Stage 2 scope Part 0-3	Appointed
Cost Benefit Analysis	Ernst & Young	Stage 2 EA for BC	Complete
Structural	Cardno	MSCP only	Appointed
Mechanical & Electrical	Umow Lai	MSCP only	Appointed
Town Planning	Oliver Klein	MSCP only	Appointed
BCA/DDA	Advance Building Approvals (ABA)	MSCP only	Appointed
Civil and Hydraulic	Warren Smith and Partners (WSP)	MSCP only	Appointed
ESD	Steensen Varming	MSCP only	Appointed
Fire safety / bush fire	Defire	MSCP only	Appointed
Sub Surface Utility	Durkin	MSCP only	Appointed
DDA	MGAC	MSCP only	Appointed
Acoustic	Arup	MSCP only	Appointed
Parking and Traffic	Parking and Traffic Consultants	MSCP & Stage 2	Appointed
Aviation	Aviation Professional Services	MSCP & Stage 2	Appointed
Contamination & Geotechnical	Douglas Partners	MSCP & Stage 2	Appointed
Surveyor	LTS Lockley	Whole of site	Appointed
Structural & Civil	Enstruct	Stage 2 only	Appointed
Mechanical	Arup	Stage 2 only	Appointed
Electrical / Fire / Comms / Security	JHA Consulting	Stage 2 only	Appointed
Hydraulics / Stormwater / Wet Fire	Donnelley Simpson Cleary Consulting	Stage 2 only	Appointed
Vertical Transportation	JHA Consulting	Stage 2 only	Appointed
Fire Engineering	Arup	Stage 2 only	Appointed
BCA / PCA	Blackett Maguire + Goldsmith	Stage 2 only	Appointed
Town Planning	Urban Ethos	Stage 2 only	Appointed
Acoustic	Arup	Stage 2 Only	Finalising Contract
ESD	Arup	Stage 2 Only	Finalising Contract
Programmer	Tracey Brunstrom & Hammond (TBH)	Stage 2 Only	Appointed
Logistics	Space 2 Develop	Stage 2 Only	Appointed
DDA	I Access	Stage 2 Only	Appointed
Kitchen	Cini Little	Stage 2 Only	Finalising Scope
Sub Surface Utility	Geoscope	Stage 2 Only	Finalising Contract
Retail Study	Tender due 6th April	Stage 2 Only	Tender Stage