Tumut Hospital Redevelopment

Business Case

Issue Date: 15 April 2019

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Version	Date	Issued To	Status
1.0	**March 2019**	**Health Infrastructure**	**Draft**
1.1	**1 April 2019**	**Health Infrastructure**	**Draft**
1.2	**3 April 2019**	**Health Infrastructure**	**Draft**
1.3	**5 April 2019**	**Health Infrastructure**	**Final Draft**
1.4	**8 April 2019**	**MLHD**	**Final**
1.5	**15 April 2019**	**MLHD & ESC**	**Final (post initial feedback from Assurance Review).**

Endorsement by:

This Tumut Hospital Redevelopment Business Case is certified to have been developed in accordance with the NSW Treasury Guidelines Business Cases (TPP 08-5).

Signed
Project Manager

The Preferred Option in this Tumut Hospital Redevelopment Business Case is certified to have been developed in accordance with the NSW Health Facility Guidelines and the Building Code of Australia.

Signed
Architect

CHIN YOUNG

The capital cost estimates in this Tumut Hospital Redevelopm0ent Business Case are certified to have been developed in accordance with Health Infrastructure's requirements.

Signed
Cost Manager

The Tumut Hospital Redevelopment Business Case has been reviewed and is fully endorsed by the Murrumbidgee Local Health District.

Signed
Chief Executive, Murrumbidgee Local Health District

The Final Business Case is certified to contain all items required for project approval and funding.

Signed
Executive Director Rural & Regional, Health Infrastructure

The Final Business Case is certified to contain all items required for project approval and funding.

Signed
Chief Executive, Health Infrastructure

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Project Team

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This Business Case incorporates the requirements of a Project Definition Plan (PDP) in accordance with the NSW Ministry of Health *Process of Facility Planning (PoFP) Guidelines.*

ABBREVIATIONS AND ACRONYMS

ABF	Activity Based Funding
ADL	Activities of Daily Living
AHIS	Aboriginal Health Impact Statement
AusHFGs	Australasian Health Facility Guidelines
BC	Business Case
BCA	Building Code of Australia
BMCS	Building Maintenance Control System
CBA	Cost Benefit Analysis
CCU	Coronary Care Unit
CDR	Concept Design Report
CSD	Central Sterile Department
CSP	Clinical Services Plan (Tumut Health Service Plan)
CWG	Communications Working Group
DPE	Department of Planning and Environment
EA	Economic Appraisal
ED	Emergency Department
EIS	Environmental Impact Statement
ERG	HI Expert Reference Group
ESC	Executive Steering Committee
ETC	Estimated Total Cost
EUG	Executive User Group
FB	Functional Brief
FIS	Financial Impact Statement
HDU	High Dependency Unit
HI	Health Infrastructure NSW
IC&T	Information Communication & Technology
IDT	Investment Decision Template
IDS	Investment Decision Submission
IPU	Inpatient Unit
IRSD	Index of Relative Socio-economic Disadvantage

ISEPP	State Environmental Planning Policy (Infrastructure)
KSO	Base Case - Keep Safe and Operational
LEP	Local Environmental Plan
LGA	Local Government Area
LHD	Local Health District
LHAC	Local Health Advisory Committee
MLHD	Murrumbidgee Local Health District
MoH	NSW Ministry of Health
MPHN	Murrumbidgee Primary Health Network
NCOS	Net Cost of Services
NEST	National Elective Surgery Targets
NGOs	Non-Government Organisations
NPV	Net Present Value
NWAU	National Weighted Activity Unit
PAC	Planning Assessment Commission
PDC	Planning and Development Committee
PDP	Project Definition Plan
PESC	Project Executive Steering Committee
POFP	Process of Facility Planning
PUGs	Project User Group(s)
REF	Review of Environmental Factors
RMS	Roads & Maritime Services
RU	Relative Utilisation
SEIFA	Social & economic index for areas
SEPP	State Environmental Planning Policy
SoA	Schedule of Accommodation
THR	Tumut Hospital Redevelopment
VM	Value Management
VMS	Value Management Study
VMO's	Visiting Medical Officers
WWBH	Wagga Wagga Base Hospital

BUSINESS CASE DELIVERABLES REGISTER

Deliverable	Status	Comments
Clinical Services Plan	V2.3	Endorsed by the MLHD Board
Masterplan Report	V8.0	Endorsed by PDC and ESC
Functional Brief	Various	Endorsed by EUG
Schedule of Accommodation	V8.7	Endorsed by EUG
Value Management Report	V2.1	Endorsed by PDC and ESC
Concept Design and Report	V3.0	Endorsed by PDC
Cost Plan and Report	V6.0	Endorsed by PDC
MLHD Resource Plan	V2.0	Endorsed by PDC
Workforce Plan	V2.0	Endorsed by PDC
Financial Impact Statement	V8.0	Endorsed by PDC
Cost Benefit Analysis	V4 .0	Endorsed by PDC
Project Governance	V3.0	Endorsed by PDC and ESC
Risk Management Plan	V3.1	Endorsed by PDC
Benefits Realisation Plan	V2.0	Endorsed by PDC
Change Management Plan	V2.2	Endorsed by PDC
Stakeholder Engagement and Consultation Plan	V1.6	Endorsed by PDC
Aboriginal Health Statement	V2.0	Endorsed by PDC
Delivery and Procurement Strategy	V3.0	Endorsed by PDC and ESC
Master Program	21 March 2019	Endorsed by PDC and ESC
ICT Strategy	V1.0	Endorsed by PDC
FFE Plan	V2.0	Endorsed by PDC
Gateway Reports	Outstanding	

1 Executive Summary

1.1 Project Description

Tumut Health Service (THS) also known as the Tumut Hospital, is a facility operating in the Murrrumbidgee Local Health District (MLHD) and is situated 400 km south-west of Sydney. The purpose of the Tumut Hospital Redevelopment (THR) project is to replace the existing ageing infrastructure of Tumut Health Service, comprising a Community Hospital and associated community health buildings, to support the safe and effective health services delivery to the population catchment.

The various buildings that comprise the existing facilities were built between the 1900s and 1960s, with some intermittent minor refurbishment works in the 1990s and in 2010. The hospital has undergone a few extensions since that time resulting in various smaller separate buildings. There are a number of buildings on campus with poor layouts resulting in suboptimal functional relationships and disjointed service delivery.

The existing buildings are at the end of their useful life and do not have the capacity to meet the approved clinical service plan, or community's health needs. They do not support effective and safe service delivery nor do they support an integration of ambulatory care or the benefits of activity based working. Through the replacement of the existing ageing infrastructure, this project will support increased service delivery of the THS providing more health services closer to home and reducing the need to transfer patients out of area.

1.2 Core Project Principles

The Project Vision statement for the THR is:

" Providing connected care experiences for better health and wellbeing"

The THR project is underpinned by the following objectives:

1. Asset replacement, as the current assets are at their end of life and do not support contemporary or efficient models of care;
2. Support integration of ambulatory care and acute care services;
3. Improve functionality and patient flow through facilities by creating greater efficiencies in the delivery of clinical services;
4. Support implementation of agreed Better Value Care models;
5. Promote wellness within the community;
6. Fulfil the role of THS as a health service hub and spoke site for Wagga Wagga Base Hospital (WWBH); and
7. Enhance staff retention and recruitment.

A new facility will enable Tumut Health Service to better fulfil its role by:

- Improving connectivity and integration between inpatient, outpatient, community, GP and specialist services by having all services under one roof and flexible clinical spaces where possible;
- Increasing clinical services capability to meet increased demand for non-tertiary care for residents in the Tumut Catchment area, thereby reducing the requirement for patients to travel to WWBH;
- Providing improved post-acute care for patients who require extended care following treatment at WWBH;
- Increasing the capability of outreach services both in person and via Telehealth;
- Improving functionality, integration of care and availability of ambulatory care services, to provide Tumut Hospital with the capacity and capability to meet demand within a slightly decreased inpatient bed base; and

The expected outcomes and key project benefits are:

- Improvement in clinical and staff safety, models of care and better patient flows through modernisation of the current infrastructure and overall improvement of interdepartmental flows, adjacencies, and functionalities;
- An integrated and contemporary health facility that efficiently supports inpatient, emergency and non-admitted patient services (outpatient, community care, and ambulatory care) to meet the projected future service demand to 2036;
- Improved accessibility for patients who would otherwise be required to travel to other hospitals to receive treatment; and
- Enhanced ambulatory/ outpatient care to manage increasing demand for services as the population ages.

1.3 Options

1.3.1 Options Considered

The options development process was informed by the Master Planning exercise completed by the MLHD and Health Infrastructure (HI) in September 2018 and was underpinned by the Tumut Health Service Plan.

The Master Planning considered potential zonal development options on the existing Tumut Hospital site and undertook an initial review and test-fit of building envelopes. The Master Plan report identifies the preferred single-storey build option for further development throughout the Business Case stage.

In January 2019, following the Investment Decision submission process, the Project Team and Executive User Group (EUG) undertook a Value Management Study (VMS) to further develop a scope that meets the service and facility needs of the Tumut community within the $50m capital funding envelope.

The following shortlisted options were assessed in the Cost Benefit Analysis (CBA):

Option	Description
Option 1 **ETC: $1m**	**Base Case** • Keep safe and operating.
Option 2 **ETC: $50m**	**A mix of new build and minor refurbishment to meet service statement need** • Construction of a new purpose-built facility to accommodate inpatient, emergency and a limited number of ambulatory care services. • Undertake minor refurbishment to the existing community / mental health /staff accommodation building (Building 3) and the existing renal dialysis demountable building (Building 7). This would likely result in continued inefficient utilisation of office accommodation space and poor functional relationships, with some clinical services becoming even less integrated.
Option 3 **ETC: $50m**	**A full new build to address service statement need** • Construction of a new purpose-built facility to accommodate all inpatient, emergency, ambulatory care services (including community health, mental health and renal dialysis). • Exploring alternative non-capital solutions for staff accommodation.

Table 1: Options Comparison

1.3.2 Preferred Option

The Preferred Option below (Figure 1) was selected on the basis that it successfully achieves all the agreed key criteria which are based upon established Master Plan Design and overarching Project Principles:

Key Criteria	Preferred Option - New Build
All Services 'under one roof'	Single building comprising all services under one roof
Single public point of entry	Single public entry point
Service flexibility & sharing of facilities	Interrelated services located to maximise the benefits of functional adjacencies and operational flows
Align with Health Service Plan	1 ED treatment space removed & alternative non-capital solutions for staff accommodation
Achieve high design quality	Design of new facility supports current and future standards and models of care
Clinical and support services not compromised (safety & efficiency)	New facility meets best practice standards for clinical safety and supports efficient delivery of services

Table 2: Preferred Option – Key Criteria

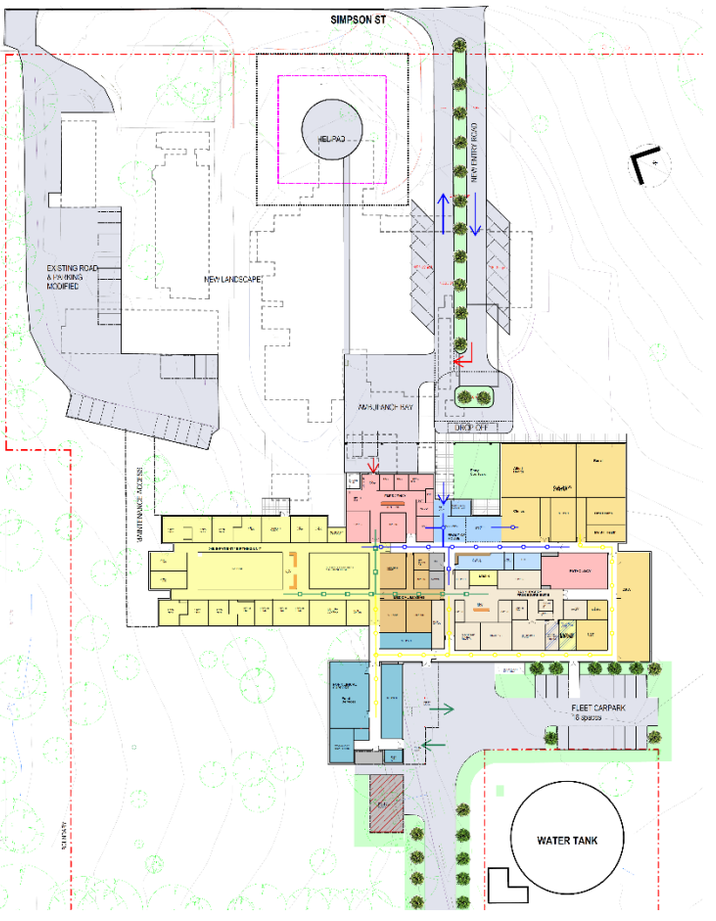


Figure 1: Preferred Option

1.3.3 Project Delivery and Procurement Approach

A two (2) stage delivery methodology, delivered via a single contract has been assessed as being the most suitable delivery and procurement strategy for the Project. The scope will include the following:

1) Construction of enabling works with design finalisation as required (Design Finalisation and Construction); and
2) Design finalisation and construction of main works based on nominal 70% Design Development documentation and novation of selected Capital consultants.

This is in line with the NSW Government's Agency Accreditation Scheme for Construction for planning and delivery of construction projects. This is further articulated in the Project Procurement Strategy included at Appendix 17.

1.4 Affordability

1.4.1 Capital Costs

The Estimated Total Cost (ETC) of the Project is $50m, based on a gross floor area (GFA) of 4,535 sqm.

The Capital Cost Plans of Option 2 and Option 3 were prepared by Concept 2 Reality (C2R) consulting based on the final Schedule of Accommodation (SoA):

- **Base Case (Option 1)** identifies that in 2020/21, $1m of capital expenditure will be required for maintenance of the existing asset to ensure continuation of safe service delivery.
- **Option 2** reflects the future capital expenditure of [$8m] in 2032 for the replacement of the existing community/mental health/staff accommodation building and renal dialysis demountable unit.
- **Option 3** assumes no future capital cost for the existing assets, as all existing assets are to be demolished (demolition costs are included in the Capital Cost Plan). All capital costs will be allocated to the construction of the new facility.

Capital cost	Total Estimated Costs	Cost escalation	Capital cost excluding escalation
Option 1 - Base Case	1.0	Nil	Nil
Option 2	50.0	1.8	48.2
Option 3	50.0	1.8	48.2

Source: C2R consulting.

Table 3: Estimated Total Costs ($m)

1.4.2 Recurrent Costs

Operating cost impacts have been assessed and presented in the Financial Impact Statement (FIS) prepared by the MLHD, as shown in Table 4 below. Additional operating cost is associated with staffing impact (1.89 FTE) of new renal chairs within the Wellness Centre, CT scanner lease and running costs (which are offset by private patient fees) and recurrent repair, maintenance and replacement (RMR) costs.

Option	2018/19 Current	2022/23	2026/27	2031/32
Option 1 - Base Case	10.1	10.1	10.1	10.1
Option 2	10.1	10.9	10.9	10.9
Option 3	10.1	10.8	10.8	10.8

Source: Option 3 MLHD. Option 2 is high-level estimates only.

Table 4: Operating Costs excluding RMR, depreciation ($m)

1.4.3 Cost Benefit Analysis

Based on the quantitative analysis of the costs and benefits of the Project, the present value of the incremental costs of Option 2 and Option 3 as compared to the Base Case are presented in Table 5 below:

Present Value (PV) (20 years @ 7%)	Option 2	Option 3
Incremental costs		
Capital costs	38.2	38.2
Operating costs (excluding maintenance costs)	6.1	5.7
Recurrent replacement, maintenance and repair (RMR) costs	3.2	2.5
Life-cycle capital maintenance costs	3.8	3.6
Future cost to replace Building 3 & 7	3.2	-
Total incremental costs	**54.4**	**50.0**
Incremental benefits		
Improvement in patient's health outcomes:		
• Inpatient care (acute and subacute)	43.1	43.1
• Renal dialysis	3.6	3.6
Avoided costs – NAPS	2.6	2.6
Avoided travel costs	0.01	0.01
Residual value	5.2	3.6
Total incremental benefit	**54.5**	**52.8**
Incremental NPV	**0.1**	**2.8**
BCR	**1.00**	**1.06**

Table 5: Key Results, Incremental to Option 1 (Base Case) ($m)

The Cost Benefit Analysis (CBA) results indicate that both investment options will generate positive Net Present Values (NPV) and Benefit Cost Ratios (BCR).

Option 3 will generate a higher NPV and BCR than Option 2 due to:

- No requirement to upgrade/replace Building 3 and 7 in the future; and
- Lower operating costs related to savings in front of house staff, facility maintenance costs and recurrent RMR.

Qualitatively, Option 3 is expected to generate greater amenity, better staff and patient safety, and better facility connectivity than Option 2.

Under Option 3, the net benefits of the Project would be generated from:

- Improved patient health outcomes as a result of better integration of health services and enhanced infrastructure functionality and layouts; and
- A range of qualitative net benefits including:
    - Improved patient and staff safety, and amenity;
    - Improved operating efficiency as a result of overall improvement in infrastructure and service delivery;
    - Improved community access to health services, in particular CT and renal dialysis; and
    - Expected improvement in staff attraction and retention rates.

Combining both quantitative and qualitative assessments, Option 3 is the Preferred Option, which will generate a BCR of 1.06 and incremental NPV of $2.8m relative to the Base Case over the 20-year analysis period.

1.5 Recommendation

The Preferred Option for the THR has been developed through user group consultation and value management processes to maximise service delivery capacity within the available funding envelope. The THR will replace existing ageing infrastructure to enable the safe and efficient provision of health services to the Tumut catchment population.

It is recommended that the Business Case be approved to provide the setting of social, financial and economic parameters and benefit targets for the THR.

2 Service Delivery

Tumut Health Service (THS), also known as the Tumut Hospital, is a facility operating in the MLHD situated in the township of Tumut which is the largest town in the newly formed Snowy Valleys Council Local Government Area (LGA). Tumut is located approximately 400 km south-west of Sydney and 525 km north-east of Melbourne.

2.1 Tumut Health Service and the MLHD Catchment Area

2.1.1 Murrumbidgee Local Health District

The MLHD is one of seven (7) Rural LHDs in NSW. The MLHD covers 21 LGA's, includes 33 geographically spread health facilities and a number of Community Health centres. Most of the MLHD is considered inner regional or outer regional in terms of remoteness. The largest towns are Wagga Wagga, Griffith and Deniliquin. Albury is generally part of Albury Wodonga Health; however some MLHD health services continue to be provided in this community.

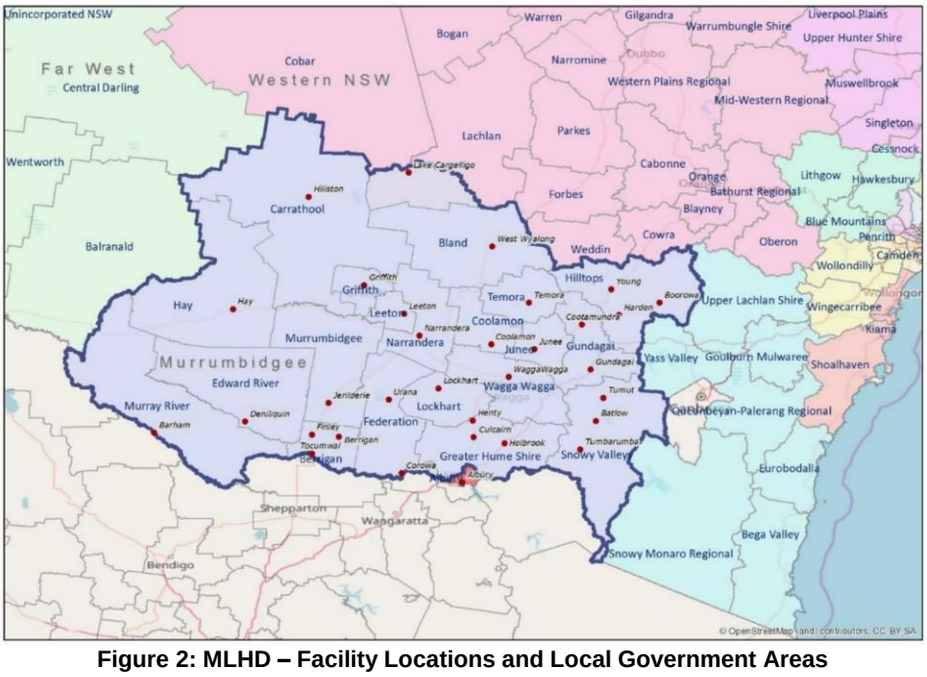


Figure 2: MLHD – Facility Locations and Local Government Areas

2.1.2 Tumut Health Service

THS is a D1a Community Hospital with Surgery, with 26 inpatient beds (including 4 Maternity beds), a Level 3 Emergency Department, Community Health Services, Clinical and Non-Clinical Support Services, Staff Accommodation, and a Helipad. The services at THS operate at a role delineation Level of 2 to 3.

Services include:

- Inpatient Medical and Surgical
- Maternity
- Surgery (at a Level 3 Role Delineation) – General, Obstetrics and Gynaecology
- Gastrointestinal Endoscopy
- Day Surgery
- Self-Care Renal Dialysis
- Dental
- Community Health
- Aboriginal Health
- Mental Health and Drug & Alcohol
- Outpatient Rehabilitation Service (commenced late 2016)
- Clinical Support Services (Radiology, Pathology, and Pharmacy)
- Non-Clinical Support Services

The catchment area for THS (Tumut Catchment) is defined as the former Tumut LGA, including the localities of Adelong and Batlow. The estimated residential population at June 2015 was 11,408. The proportion of people over the age of 70 is projected to rise. Five and a half per cent (5.5%) of residents identify as Aboriginal or Torres Strait Island peoples (ATSI).

THS is the hub site in a Hub & Spoke model with Tumbarumba and Adelong-Batlow Multipurpose Services (see Figure 3) and links with Wagga Wagga Base Hospital (WWBH) for higher level services. Outreach services are provided to small communities within the new Snowy Valleys LGA.

THS Aboriginal Health Staff service outreach sites such as the Gundagai community, which stretch to the borders of the LHD.

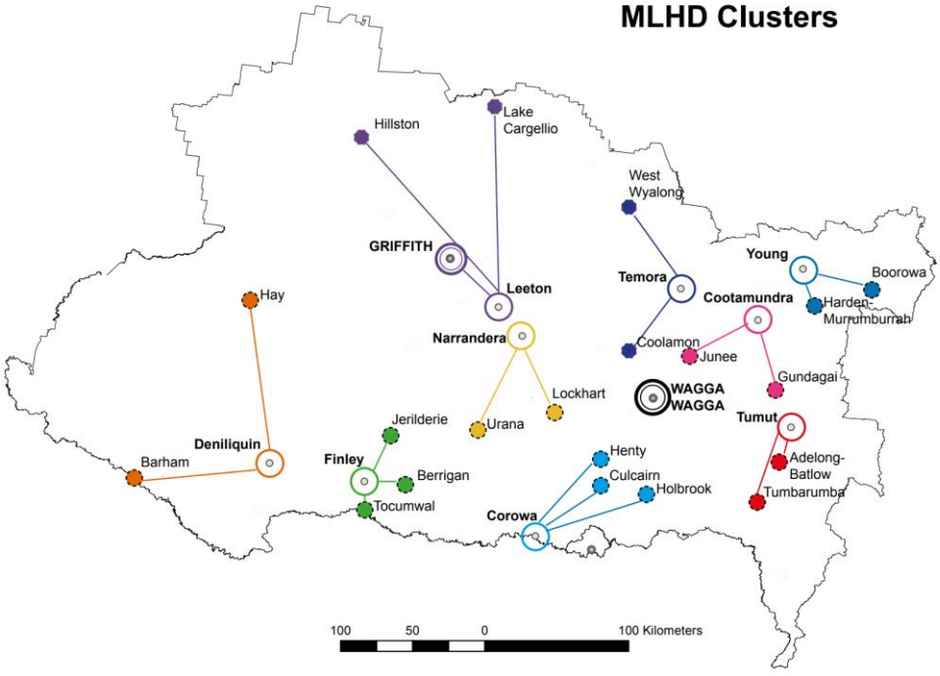


Figure 3: MLHD Clusters and THS Hub & Spoke Model

"Stand out" features impacting on health in the Tumut Catchment are:

- Ageing population; both in proportion in older age groups and actual increases in numbers of older people;
- Smoking;
- Obesity / overweight;
- Alcohol;
- Chronic Obstructive Pulmonary Disease (COPD);
- Injury hospitalisation, especially falls; and
- Relatively large Aboriginal population.

THS does not provide residential aged care. Aged care services are provided in Tumut by both BUPA and Catholic Healthcare (Blakely Lodge). Higher level services are provided at WWBH as the Major Group one, B1 Hospital in MLHD.

Close partnerships exist with the Murrumbidgee Primary Health Network (MPHN), Non-Government Organisations (NGOs) and other human service providers, to provide linked up services. A LHAC and active Hospital Auxiliary (approximately 12 active members) also support the Health Service.

2.2 Background to the Business Case

2.2.1 Terms of Reference

The documents which have been referenced in developing this Business Case are as follows:

- Tumut Health Service Plan
- Tumut Health Service Plan Background Data Book
- THS Investment Decision Template (IDT)
- MLHD's Service Agreement with the Ministry of Health
- MLHD Strategic Plan 2018-2021
- MLHD Asset Strategic Plan 2019-2020
- MLHD Goals 2018-2019
- MLHD Chief Executive Goals
- MLHD Action Plan
- MLHD Aboriginal Health Profile 2017 (Feb 2018 update)
- MLHD Rehabilitation Clinical Service Plan 2014-2018
- MLHD Renal Clinical Services Plan 2013-2017
- MLHD Mental Health and Drug and Alcohol Clinical Services Plan 2014-2019
- MLHD Aged Care Clinical Services Plan 2014-2018
- NSW State Health Plan: Towards 2021
- NSW Rural Health Plan: Towards 2021
- NSW Health Strategic Priorities 2018-2019
- NSW Aboriginal Health Plan 2013-2023.

2.2.2 Funding Announcements

On 27 August 2018, the NSW Premier, announced that the NSW Government would commit over $50 million to redevelop Tumut Hospital.

In January 2019, an Investment Decision Template (IDT) was supported by the MoH, to progress to a Final Business Case. This Business Case has been developed in line with the services and funding envelope noted in the IDT.

2.2.3 Previous Planning

Tumut Health Service Plan

The Clinical Services Plan (*Tumut Health Service Plan)* has been used to define the clinical requirements. This plan details the demographic and socio-economic status of the catchment population, future population projections, the current health service provisions and the projected future health needs of the Tumut Catchment.

MLHD Asset Strategic Plan

A redevelopment of Tumut Hospital is the highest priority of the capital projects identified in the MLHD Asset Strategic Plan.

2.2.4 Objectives of the Business Case

The purpose of this Business Case is to demonstrate the need for asset upgrade to the existing infrastructure comprising THS and highlight the value and benefit that such capital investment will bring to the residents within the Tumut Catchment population, the MLHD and the NSW Government.

This Business Case documents the proposal in detail, including justification of service rationale, identification of Concept Options to determine a Preferred Option, and subsequently a demonstration of value for money and benefits that the Preferred Option will provide. The financial requirements, both recurrent and capital, and the management case for the delivery of the Project are also presented.

2.2.5 Consultation Process to prepare the Business Case

Consultation was undertaken with the following stakeholders during development of this Business Case:

- Local Health Service staff
- MLHD service managers
- Aboriginal Community representatives
- MLHD Aboriginal Health staff
- Local Health Advisory Council
- Local Council
- Family Services
- GP Services
- Local members of the community

The Project Communications and Engagement Plan provided in Appendix 15 details the communication activities and consultation process conducted in preparation for this Business Case, together with future communications and engagement activities. Stakeholder engagement is further described in Section 7 of this Business Case.

The THR Project Team liaised with representatives from the MLHD and Tumut Hospital who form the Executive User Group (EUG). Project User Groups (PUGs) were held with a range of MLHD stakeholders, to develop the Master Plan, Functional Briefs, Schedule of Accommodation and Concept Design.

The process used to develop this Business Case has involved:

- Review of the Tumut Health Service Plan;
- A detailed Master Planning process, which included option identification and review, and detailed site surveys and site inspections of the existing site and facilities. The identification of the proposed location for the new building footprint considered site topography, construction delivery methodology, impact to existing services, and minimisation of public and clinical pedestrian and vehicular crossovers;
- EUG consultation between August 2018 and March 2019 which informed project requirements to develop Concept Design options, Functional Briefs and Schedule of Accommodation;
- Feasibility user group consultation between October and November 2018 to confirm functional adjacencies and clinical flows in order to further develop the Functional Briefs and Schedule of Accommodation;
- Sequential Cost Plan preparation to validate estimated project costs against the budget during the Master Plan and Concept Design development phases;
- EUG workshops held trhoughout March 2019 for development of the Communications and Engagement Plan, Change Management Plan and Risk Management Plan; and
- Consultation with the EUG to develop the Concept Design options and for endorsement of the preferred Concept Design Option.

2.3 The Case for Change

2.3.1 Project Objectives

This Project is underpinned by the following objectives:

- Asset replacement, as the current assets are at their end of life and do not support contemporary or efficient models of care;
- Support integration of ambulatory care and acute care services;

- Improve functionality and patient flow through facilities by creating greater efficiencies in the delivery of clinical services;
- Support implementation of agreed Better Value Care models;
- Promote wellness within the community;
- Fulfil the role of THS as a health service hub and spoke site for WWBH; and
- Enhance staff retention and recruitment.

A new facility will enable THS to better fulfil its role by:

- Improving connectivity and integration between inpatient, outpatient, community, GP and specialist services by having all services under one roof and flexible clinical spaces where possible;
- Increasing clinical services capability to meet increased demand for non-tertiary care for residents in the Tumut Catchment area, thereby reducing the requirement for patients to travel to WWBH;
- Providing improved post-acute care for patients who require extended care following treatment at WWBH;
- Increasing the capability of outreach services both in person and via Telehealth;
- Improving functionality, integration of care and availability of ambulatory care services to provide Tumut Hospital with the capacity and capability to meet demand within a slightly decreased inpatient bed base; and
- Improving design efficiencies to optimise capacity and capability to meet service demand.

The expected outcomes and key project benefits are:

- Improvement in clinical and staff safety, models of care and better patient flows through modernisation of the current infrastructure and overall improvement of interdepartmental flows, adjacencies, and functionalities;
- An integrated and contemporary health facility, that efficiently supports inpatient, emergency and non-admitted patient services (outpatient, community care, and ambulatory care), to meet the projected future service demand to 2036;
- Improved accessibility for patients who would otherwise be required to travel to other hospitals to receive treatment; and
- Enhanced ambulatory/ outpatient care, to manage increasing demand for services as the population ages.

2.3.2 Drivers for Change

The key drivers in the Case for Change for the THR comprise the following:

1. Asset Condition and Functionality

The existing infrastructure is ageing, does not meet contemporary service delivery requirements and reduces opportunities for implementing integrated care and ambulatory care across multiple service settings.

Current issues impacting functionality include:

- Most of the buildings and infrastructure are outdated and pose multiple challenges, including non-compliance with building regulations, building standards and health guidelines;
- Services are in various buildings on the site which limits optimal service integration, coordination of care and reduces the capacity to share administrative functions. In addition, the disparate buildings provide a barrier to improving staff and patient safety; and

- Limited availability of clinic/ consultation space reduces opportunities to host visiting services including specialist clinics and outreach services. Outpatient rehabilitation services are currently provided in a small meeting room which does not meet AusHFG standards, putting staff and patients at risk. In addition, access to these areas is through back of house service areas.

2. Implementing Better Value Care models

A key priority within the MLHD Strategic Plan is a "Focus on Wellness" which aims to:

- Support people and communities to learn about and become responsible for improving their own health and wellbeing;
- Shift the balance of care from hospitals to integrated primary and community-based services; and
- Seize every interaction as an opportunity to focus on wellness.

The redevelopment of Tumut Hospital is the highest priority in the MLHD Asset Strategic Plan. Other Capital Works projects currently underway at MLHD, include Wagga Wagga Base Hospital Stage 3 and Griffith Base Hospital Redevelopment. These redevelopments have a strong focus on the implementation of the MLHD Strategic Plan's "Focus on Wellness", with the provision of integrated ambulatory care services (Wellness Centres) being the key project drivers.

The progression of the THR will enable improved integration of primary and community health services in line with MLHD's strategic priorities. The existing infrastructure is unable to accommodate the models of care required to meet future service demand in a safe and efficient manner. This deficit is in evidence where Mental Health, Allied Health and Outreach services are delivered from separate buildings providing a barrier to service integration.

THR will improve care across a number of departments within the THS including:

- **Reconfiguration of Birthing Services**: The establishment of a birthing "pod" within the inpatient bed base will improve bed utilisation and support the continued provision of maternity services operating as part of a District wide network, with women risk-assessed and transferred to higher level services at WWBH if required.
- **Wellness Centre & Ambulatory Care**: Development of a Wellness Centre to support the expansion of ambulatory care services and improve integration of care between departments through the co-location of:
  - Ambulatory Care services
  - Chair-based services: (renal, infusion/ transfusion, dental)
  - Outpatient services
  - Rehabilitation services
  - Visiting specialist services
  - Community Health
  - Aboriginal Health
  - Mental Health and Drug & Alcohol

The facility will support the provision of a range of service models including:

- Individual and group services face-to-face and via Telehealth;
- Outreach (visiting) services such as visiting specialists and District-wide services;
- GP/ specialist clinics to enable integrated services and to attract clinicians locally. Some rooms could potentially be used for after-hours GP services;
- 12-hour and 24-hour zone to provide extended hours of service; and
- Interrelated services co-located to maximise the benefits of functional adjacencies and operational flows.

Establishment of ambulatory care services will provide alternatives to hospital admission to manage the increasing demand for inpatient services within projected inpatient beds. The facility will also improve efficiencies with community services able to be offered in a centralised location and at home.

Currently some community services are only offered at home which creates inefficiencies (due to staff travel time and requirement to transport equipment).

- **Emergency Department**: A significant proportion of Emergency Department activity is non-urgent and care could be provided through outpatient clinics and pre-arranged admissions. Establishment of ambulatory care services will provide opportunities to divert non-emergency care to more appropriate settings and allow reorganisation of activity to improve staffing efficiencies and patient flows.
- **Surgery:** Expansion of surgical services has the potential to redirect residents from the Tumut Catchment and Gundagai away from WWBH to Tumut Hospital for appropriate surgery. Visiting surgical teams will increase access to additional specialties and augment the current GP Visiting Medical Offers (VMO) workforce to ensure ongoing viability of the service into the future. Tumut Hospital will focus on day only, minor, and some common/ intermediate surgical procedures. Further enhancement of surgical services will build on the recently established gastrointestinal endoscopy (scopes) services.
- **Renal Dialysis:** Tumut Hospital currently provides self-care or assisted self-care renal dialysis services to residents of the catchment area travelling to WWBH for centre-based dialysis. It is projected a satellite dialysis service will be required in the next 10 years which will reduce travel time and costs for patients. There are currently 3-4 Tumut residents travelling to WWBH for satellite dialysis, which could be delivered locally. To enable this, the service would need to be upgraded from self-care to Level 3 role delineation.
- **Radiology:** Public CT scanning services at Tumut Hospital (including weekends and after hours) will reduce travel time and costs for patients and the health service.
- **Rehabilitation:** Expansion of inpatient and outpatient rehabilitation programs will reduce demand for slow stream rehabilitation at WWBH. Consideration will be given to the establishment of prehabilitation programs to enhance physical function prior to surgery, reduce de-conditioning and improve recovery time (particularly relevant in view of the ageing of the population in small rural communities).
- **Telehealth:** Improved digital capability to fully utilise Telehealth services and provide a broader range of specialty services to the community e.g. paediatric services. Telehealth services will augment outreach models of care which have inherent inefficiencies with the available clinical time at the outreach site affected by travel time.

3. Self-Sufficiency, Accessibility and Equity of Service

Despite the geographical issues, the majority of hospital care for residents within the Tumut Catchment is currently provided outside Tumut. In 2015/16, Tumut Hospital provided around one third of hospital care for Tumut Catchment residents with services also provided by:

- WWBH;
- Private health services; and
- A small proportion of services provided by the ACT.

Patient flows to other services (WWBH) and private services were predominantly for orthopaedics, acute psychiatry, rehabilitation respiratory medicine and cardiology. Satellite renal dialysis is mainly undertaken at WWBH with chemotherapy exclusively provided in the private sector. The majority of people accessing services at THS were from the Tumut Catchment area (91% separations and 93% bed days).

Public transport options are limited to a bus service from Tumut to Wagga Wagga (operated by Transport NSW) which operates 3 days per week, with variable reliability in winter arriving in Wagga Wagga early afternoon. This would necessitate afternoon appointments and a late return time; an unacceptable mode of transport for the majority of patients.

2.4 The Strategic Case

The THR is aligned with the strategic directions of the Australian Government, NSW Government, NSW Ministry of Health (MoH), MLHD, and Local Government. A summary of key policy and planning framework of each of these stakeholders is provided in the following table.

Australian Government	• A reduction in the incidence of preventable mortality and morbidity • Improved access to, and efficiency of, public hospitals • Improved capacity, quality and safety of Australia's health care system to meet current and future health needs including through investment in health infrastructure • Improved capacity, quality and mix of the health workforce to meet the requirements of health services
NSW Government	• Keep people healthy and out of hospital • Provide world class clinical services with timely access and effective infrastructure • Delivering truly integrated care • Access to high quality care for rural populations
NSW Ministry of Health	• Keep people healthy, provide world class clinical care, and deliver truly integrated care • Support and develop the workforce, support and harness research and innovation, enable E-health, and design and build future-focused infrastructure Generate new evidence and translate knowledge into the delivery of a better health system and improve health
Murrumbidgee Local Health District	• Focus on providing integrated Wellness Centres, that provide holistic patient centred models of care • Improve access to clinical services • Improve the patient experience • Increase the use of Telehealth • Improve the safety, culture and wellbeing of the workforce, and increase the proportion of Aboriginal Workforce

Table 6: Summary of Strategic Directions

2.4.1 Australian Government

The Australian Government has identified a broad range of health priority areas. Key priority areas relevant to the THR include:

Outcome 1 **Population Health**	A reduction in the incidence of preventable mortality and morbidity, including through national public health initiatives, promotion of healthy lifestyles, and approaches covering disease prevention, health screening and immunisation.
Outcome 4 **Acute Care**	Improved access to, and efficiency of, public hospitals, acute and sub-acute care services, including through payments to state and territory governments.

Outcome 5 **Primary Health Care**	Access to comprehensive primary and mental health care services, and health care services for Aboriginal and Torres Strait Islander peoples and rural and remote populations, including through first point of call services for the prevention, diagnosis and treatment of ill-health and ongoing services for managing chronic disease.
Outcome 7 **Health Infrastructure, Regulation, System and Quality**	Improved capacity, quality and safety of Australia's health care system to meet current and future health needs including through investment in health infrastructure, regulation, international health policy engagement, research into health care, and support for blood and organ donation services.
Outcome 8 **Health Workforce Capability**	Improved capacity, quality and safety of Australia's health care system to meet current and future health needs including through investment in health infrastructure, regulation, international health policy engagement, research into health care, and support for blood and organ donation services.
Outcome 9 **Biosecurity and Emergency Response**	Preparedness to respond to national health emergencies and risks, including through surveillance, regulation, prevention, detection and leadership in national health coordination.

Table 7: Key Priorities – Australian Government

2.4.2 NSW Government

NSW 2021 – A Plan to make NSW Number One

NSW 2021[1] sets the Government's agenda for change in NSW.

It is a 10-year plan to rebuild the economy, return quality services, renovate infrastructure, restore accountability to government, and strengthen local communities.

NSW 2021 is the NSW Government's strategic business plan, setting priorities for action and guiding resource allocation. Each strategy is supported by goals, targets and priority actions.

Key goals for health and their application to the THR are further articulated below:

Goal 6 **Strengthen the NSW Skill Base**	Build an educated and skilled workforce to drive a productive and growing economy. Find ways to work collaboratively across government, industry and tertiary sectors to develop a skill base that meets the current and future needs of NSW businesses. The delivery of high quality, accessible and relevant training will support workforce participation and the growth of industry and business.
Goal 11 **Keep people healthy and out of Hospital**	• Reduce smoking rates • Reduce overweight and obesity rates • Reduce risk drinking • Close the gap in Aboriginal infant mortality • Reduce potentially preventable hospitalisations

[1] *https://www.ipc.nsw.gov.au/sites/default/files/file_manager/NSW2021_WEBVERSION.pdf*

	The THR will facilitate the implementation of new models of care aimed at concentrating knowledge, skills and resources around the needs of the patient. These will be central to keeping people healthy, enhancing the patient journey (and satisfaction), enhancing patient outcomes, enhanced service integration, and reducing unplanned admissions by earlier identification and management of patients' needs by the right team at the right time and in the right environment
Goal 12 **Provide world class clinical services with timely access and effective infrastructure**	• Improved regional access (closer to home) • Integration of new technologies and integration through technology across the district • Increase patient satisfaction • Improve accessibility and self-sufficiency of service
Goal 13 **Better protect the most vulnerable members of our community and break the cycle of disadvantage**	Building trust through partnerships Implementing what works and building the evidence Integrated planning and service delivery Strengthening the Aboriginal workforce Providing culturally safe work environments and health services Strengthening performance monitoring, management and accountability
Goal 19 **Invest in critical infrastructure**	Increase expenditure on critical NSW infrastructure. Prioritise and deliver infrastructure in partnership with the private sector. The THR is critical to the ongoing delivery of health services to the MLHD and Tumut Catchment area.

Table 8: Key Goals – NSW Government

2.4.3 NSW Ministry of Health

NSW State Health Plan – Towards 2021

The *NSW State Health Plan – Towards 2021* provides the strategic framework which brings together NSW Health's existing plans, programs and policies and sets priorities across the system for the delivery of the 'the right care, in the right place, at the right time' for everyone. The *NSW State Health Plan* lays out the directions and strategies which will not only shape how the NSW public healthcare system will develop, but establishes the common values, actions, policies and programs that will be required to get there over the next decade.

Three key directions and four key strategies underpin the *NSW State Health Plan*:

Direction	Strategy	Tumut Hospital Redevelopment
Direction One. Keeping people healthy	**Strategy One.** Supporting and Developing our Workforce	The THR supports new models of care with an emphasis on integrated care in partnership with primary care providers, focusing on streamlining the patient journey, improving the patient experience and clinical outcomes to meet emerging health issues. The Project enables the THS workforce to deliver first class, patient-centred care within the CORE values framework – *Collaboration, Openness, Respect and Empowerment*. The Project will support the delivery of seamless integrated care by promoting local health pathways
Direction Two. Providing World-Class Clinical Care	**Strategy Two.** Supporting and Harnessing Research and Innovation	
Direction Three. Delivering Truly Integrated Care	**Strategy Three.** Enabling eHealth	

	Strategy Four. Designing and Building Future-Focused Infrastructure	and strengthen partnerships with the primary and community care sectors for improved service accessibility The Project will deliver improved facilities and equipment to support the delivery of care. The THS Redevelopment project is strongly supported by the local community, clinicians and the MLHD Board as a means to provide timely and localised access to and improved patient care.

Table 9: Key Directions and Strategies - NSW Ministry of Health

NSW Rural Health Plan Towards 2021

The *NSW Rural Health Plan* highlights the need to invest in infrastructure, new models of care, research and eHealth technology. It notes that it is fundamental to ensure the rural health workforce is sustainable and is meeting the needs of communities. This plan highlights the important role NSW hospitals and health facilities play and recognises the need to work closely with general practitioners and other primary care providers such as practice nurses, psychologists, physiotherapists and community health workers.

The THR directly responds to these objectives, specifically regarding the integrated care that will be provided within the multi-functional space at the Wellness Centre.

NSW Integrated Care Strategy

The *NSW Integrated Care Strategy* articulates a commitment towards transforming the delivery of care to improve health outcomes for patients and reduce costs deriving from inappropriate and fragmented care, across hospital and primary care services including via:

- Designing better connected models of healthcare to leverage available service providers to meet the needs of smaller rural communities.
- Developing New Ways Of Working (NWOW) (or Activity Based Working) across State government agencies and with Commonwealth funded programs to deliver better outcomes for identified communities.
- Providing greater access to out-of-hospital community-based care, to ensure patients receive care in the right place for them.

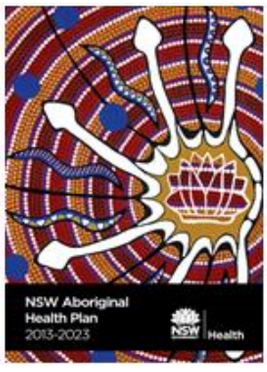
The following documents were also considered:

NSW Health Strategic Priorities 2018-19

NSW Rural Health Plan Towards 2021

The Premier's Priorities 2018 Update

NSW Aboriginal Health Plan 2013-2023



2.4.4 Murrumbidgee Local Health District

MLHD Strategic Plan 2016-2021

The *MLHD Strategic Plan 2016-2021* identifies excellence, people, partnerships and wellness as the principles by which MLHD will achieve the strategic vision. The Plan embraces themes of seizing opportunity, collaboration, utilising the skills of staff and striving to provide the best models of care for patients.

The *MLHD Strategic Plan 2016-2021* identifies four (4) priorities for the subsequent 5 years, and the values and foundations that underlie them.

The four priorities identified are:

- Focus on Wellness
- Invest in our people
- Together in partnership
- Aspire to excellence

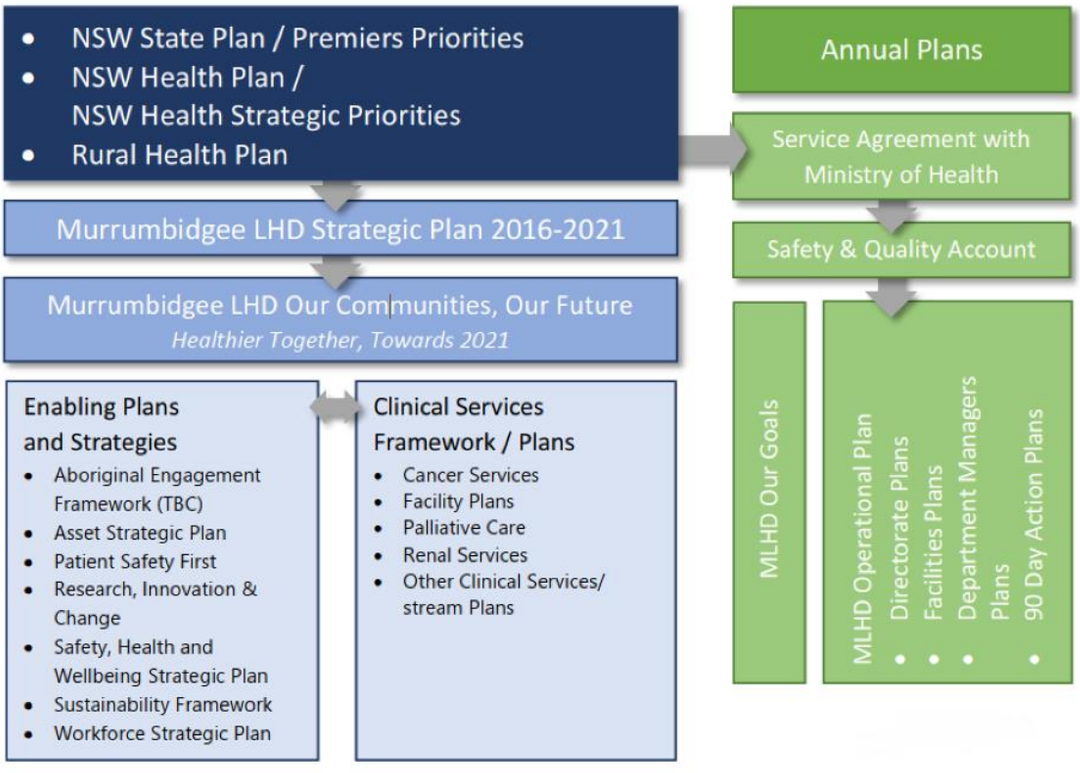


Figure 4: MLHD Hierarchy of Plans

2.5 Option Analysis

2.5.1 Non-Capital Solutions

For the items that were not included in the CSP prioritised scope, the EUG identified a number of provisional options that could be implemented to continue provision of these services. These non-capital solutions will continue to be developed and refined as the project progresses.

Scope item	Solution	Description
On-site Staff Accommodation	Non-capital	Accommodation options are currently being explored.
Equipment Loan Pool	Non-capital	This service has been decreasing in recent years due to patients increasingly procuring their own equipment and/or using third party leasing options. There are recurrent cost reductions in not having to maintain this service in the future.
Medical Records Store	Technology & Non-capital	MLHD is currently rolling-out a forward scanning program, whereby medical records are scanned as patients are discharged with the paper records ultimately destroyed. Tumut has been brought forward in the rollout of this program. The strategic trends for medical records are the in-time, paper-based records which will continue to decrease in volume as utilisation of electronic records continues to increase.

7th Emergency Department (ED) Treatment Space	Service Review	The current ED has 3 treatment spaces. A review of the CSP projections concluded that while ED activity will increase, an additional 3 spaces will still meet the clinical demand for emergency services.
CT Scanning Equipment	Non-capital	MLHD is exploring non-capital solutions for the procurement of the CT equipment (which is outside the Project Scope). The Project Team have maintained the CT room and facilities in scope. These areas will be fitted out (warm shell) to facilitate the equipment installation. The Base Case included in the FIS notes that new equipment will be leased and serviced on a long-term contract.

Figure 5: Non-Capital Solutions for items not in Project Scope

2.5.2 Capital Redevelopment

The THR Project Team began the Master Planning Phase in June 2018. An EUG was established to identify optimum functional adjacencies and a preferred Master Plan option through an options development process. Master Plan Option 3B below was identified as the Preferred Option.

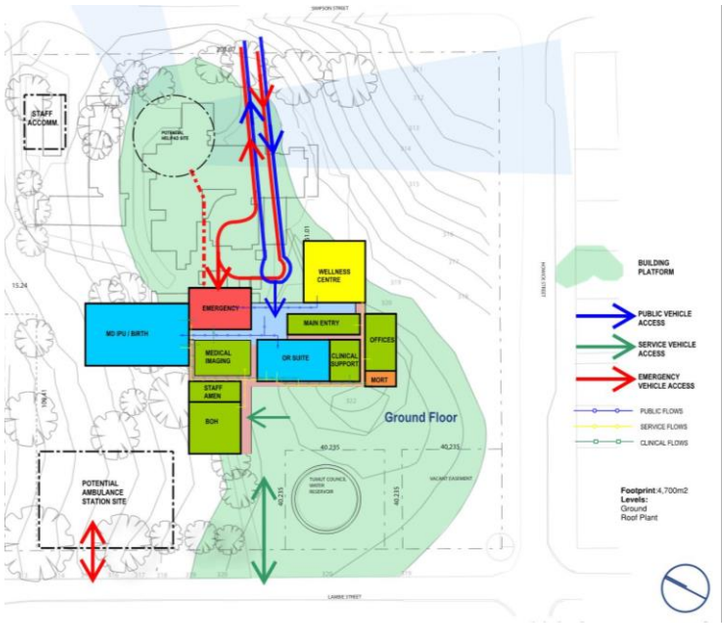


Figure 6: Option 3 B (preferred)

The strengths and weaknesses of Option 3B are detailed in Table 10 below:

Option 3B	
Strengths	**Weaknesses**
• Optimal functional relationships / operational efficiency • No crossover of internal flows • Good fit with the topography, all in one level • IPUs are facing north and take advantage of the views on both sides	• Boiler house demolished (temporary works required)

Table 10: Preferred Option 3B – Strengths and Weaknesses

During the Master Planning and Functional Briefing phase, the nominal funding envelope for the Project was identified as $55m (as noted in the MLHD Asset Strategic Plan). However, during the Concept design phase, an Investment Decision Template (IDT) was completed to confirm the final funding envelope. The IDT was approved in January 2019 with a funding envelope of $50m.

The Project Team employed the following process to develop the Project Scope within the revised $50m budget:

1. Review of the clinical and support services priorities. The CSP defined the clinical and support services scope and then undertook a prioritisation process to align with MLHD strategic priorities;

2. The Schedule of Accommodation developed in parallel with the Functional Briefing process, was subjected to a full review and test fit. This process also incorporated the outcomes of the prioritisation process; and

3. Review the infrastructure options for the Project:

    a) Option 1 – Base Case (keep safe and operating);

    b) Option 2 – Partial replacement of the onsite buildings, whilst retaining buildings 3 and 7 and reducing new building area; or

    c) Option 3 – (Preferred) Full asset replacement in alignment with a Schedule of Accommodation reflecting contemporary and efficient operational models (i.e. New Ways of Working), and some non-capital solutions.

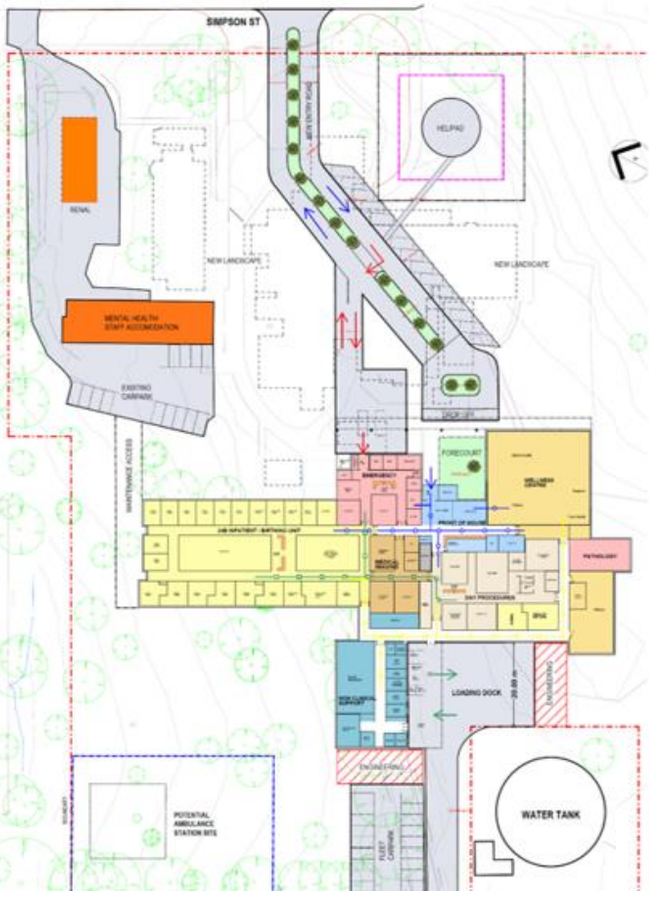


Figure 7: Option 2 – Retain Existing Buildings

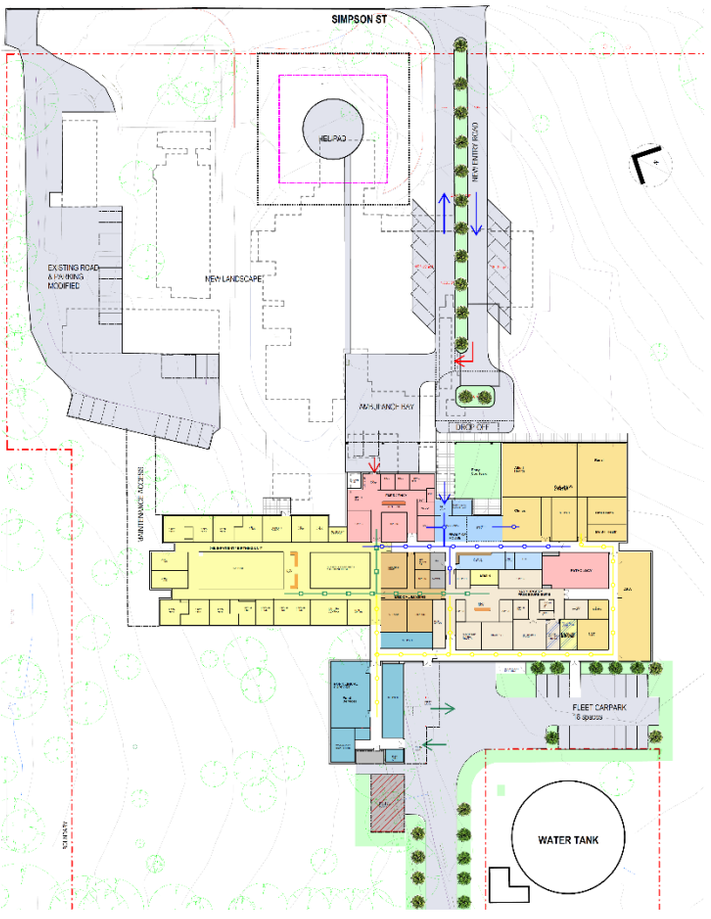


Figure 8: Option 3 – Full Asset Replacement

Following the option review by the EUG in December 2018 and MLHD Executive in February 2019, Option 3 was identified as the Preferred Option. This was supported by the Executive Steering Committee (ESC) in March 2019.

The assessment was based on criteria from the Master Planning process. The options assessment outcomes are as follows:

Criteria	Option 1 Base Case	Option 2 (Refurb & New Build)	Option 3 (New Build)
All services ‘”under one roof”	5 different buildings	3 different buildings	Single building with all services under one roof
Single public point of entry	Multiple points of entry	3 points of entry	Single public entry point
Service flexibility & sharing of facilities	Interrelated services provided in separate buildings	Mental health interview rooms could only be used by Mental Health.	Interrelated services located to maximise the benefits of functional adjacencies and operational flows
Align with Health Service Plan	Does not implement any of the new models of care,	1 ED treatment space removed	1 ED treatment space removed & non-capital

Criteria	Option 1 Base Case	Option 2 (Refurb & New Build)	Option 3 (New Build)
	including the Renal and CT Services.		staff accommodation solution
Achieve high design quality	Building are currently in poor condition and at the end of their lifecycle.	2 Buildings lightly refurbished, with a limited future lifespan, it would not provide a long-term facility solution	Design of new facility supports current and future standards for models of care
Clinical and support services not compromised (safety & efficiency)	Clinical safety compromises, with disjointed logistics for support services	Clinical safety compromises, with disjointed logistics for support services.	New facility meets standards are best practices for clinical safety and supports efficient delivery of services

Table 11: Options Assessment Comparison

2.6 Preferred Option & Concept Design

The Preferred Option (Figure 9) was selected as it met the key Master Plan design principles and key overarching Project Principles. The key assessment criteria included:

Key Master Plan Design Principles:

- All services under one roof;
- Single public point of entry; and
- Service flexibility & sharing of facilities (including shared consulting rooms within the Wellness Centre).

Key Overarching Project Principles

- Align with the Tumut Health Service Plan;
- Achieve high quality design whilst incorporating future flexibility; and
- Clinical and support services not compromised (safety & efficiency).

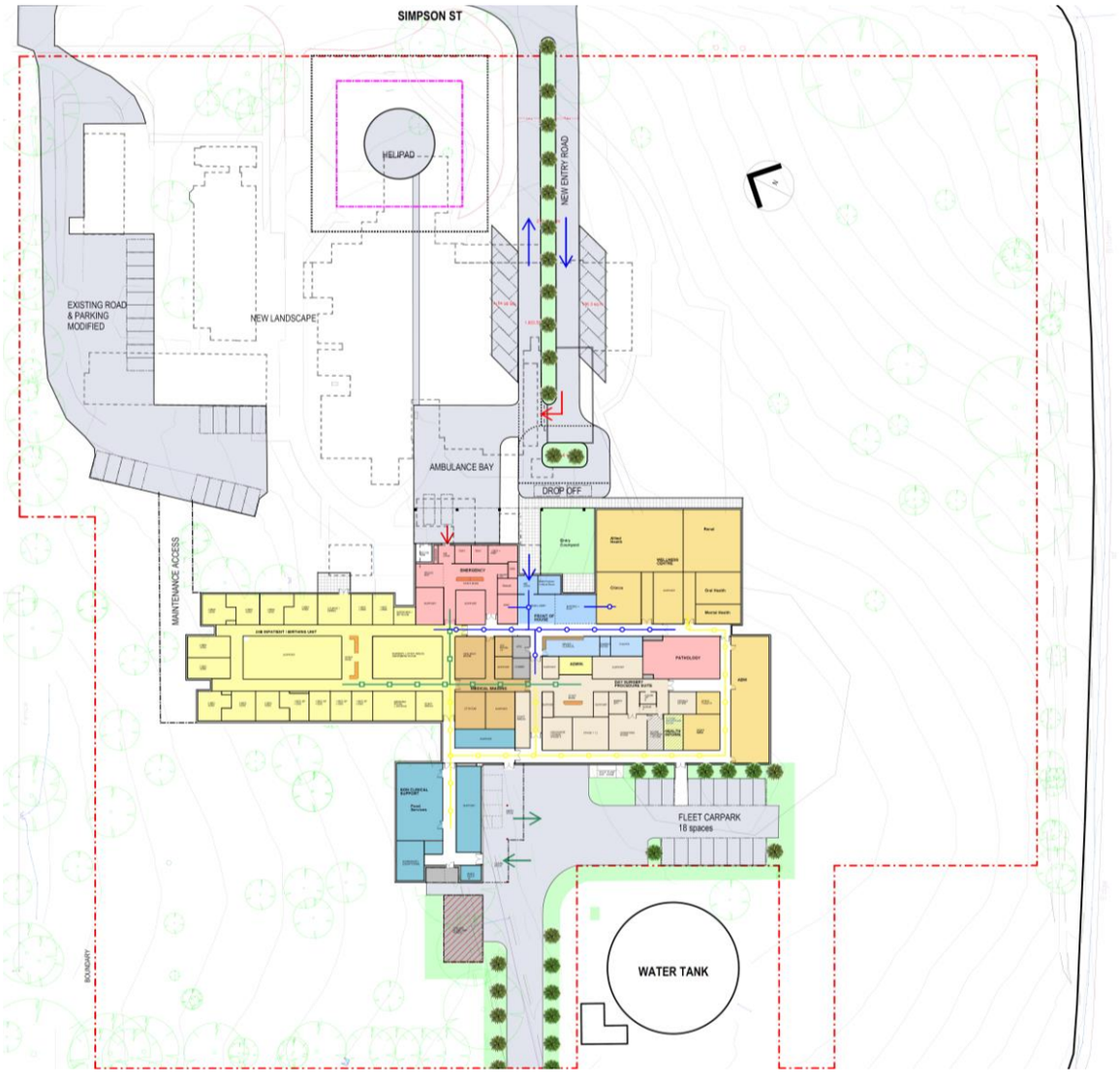


Figure 9: Preferred Option 3

When identifying the Preferred Option, key site and project constraints were considered and it was determined that the Preferred Option is able to successfully achieve the following:

- Continuous operation of the existing facility until the new facility has been constructed and commissioned; and
- Delivery of an efficient solution given topographical constraints comprising a central ridge running north-south at the centre of the site with falls on either side.

The Preferred Option facilitates a significant improvement in the number and quality of services able to be provided by MLHD from this site. The new facility will facilitate greater efficiencies and improved quality of care for patients through the achievement of a key design principal of collocation of all services under one roof.

The introduction of the Wellness Centre into the facility is an MLHD initiative to enable connective care experience for patients where new and expanded models of care can be introduced. Additionally, it will provide an opportunity for non-clinical staff to collaborate and work closely together with clinicians. The new model will improve communications and coordination between services such as mental health, community health, Aboriginal health, rehabilitation, GP's and specialists resulting in better overall health service delivery for the community. To meet the future increase in service demand, future proofing of the new facility has been provisioned within the design and includes the ability to extend the Wellness Centre if required.

Table 12 highlights the current and proposed provision of services at Tumut Hospital as indicated in the Tumut Health Service Plan (CSP).

Service	CSP Numbers	Short-listed options		
		Option 1 Base Case	Option 2 $50m ETC	Option 3 $50m ETC
Inpatient beds	24	26	24	24
Emergency treatment	7	3	6	6
Renal Chairs & Medical Day only	6 co-located chairs: (4 renal dialysis satellite chairs & 2 medical day-only chairs)	3 (renal self-service	6 co-located chairs: (4 renal dialysis satellite chairs & 2 medical day-only chairs)	6 co-located chairs: (4 renal dialysis satellite chairs & 2 medical day-only chairs)
Birthing & Assessment Rooms	2	2	2	2
Neonatal Nursery & Resuscitaire	2	1	2	2 cots + 1 resuscitaire
Dental Chairs	1	1	1	1
Ambulatory Care Services (Gym & Inpatient Lounge)	3	3	2 (as per functional briefing)	2 (as per functional briefing)
Outpatient/Community Health/MHDA Clinics	9	2	7 new 2 refurb	9
Theatre	1	1	1	1
Recovery beds	2	2	2	2
Medical Imaging	Yes	Yes	Yes	Yes
- Ultrasound and X- Ray	Yes	Yes	Yes	Yes
- CT Scan Facilities	Yes	Yes	Yes	Yes
- CT Scanner (MM&E Leased)	Yes	No	Yes	Yes
Staff Accommodation	5	3 (as is)	3 Refurbished on site	Off-site option to be explored
Helipad, kitchen, maintenance	Yes	Yes	Yes	Yes

Table 12: Comparison of service configurations between Options

2.6.1 Concept Design

The projected service demand and facility requirements of the THR are outlined in the CSP. As identified above, as part of the Concept Design process the options that were identified for further consideration as follows:

- Option 2 – Partial replacement; retain Buildings 3 and 7; or
- Option 3 – Full replacement to address service statement need.

These options were presented to the EUG and MLHD Executive which identified Option 3, as the Preferred Option. Option 3 resulted in a reduced area requiring the development of a revised Schedule of Accommodation (SoA). The revised SoA was endorsed by the EUG in January 2019 and was the basis for Concept Design development.

The Concept Design was presented to the EUG and the MLHD Executive to review and validate adjacency requirements, paths of travel and location of clinical units as per the endorsed Functional Briefs were met.

The Concept Design was endorsed by the EUG on 18 February 2019.

2.6.2 Design Planning Principles

The Concept Design responds to and confirms Master Plan assumptions with respect to accessibility, functional requirements and clinical adjacencies.

Functional Briefs have been prepared through EUG and PUG consultation and include agreed overarching and specific operational policies for the Project.

The agreed principles for the Project that have been achieved in the Master Plan and Concept Design include:

- Clinical services under one roof;
- Single public point of entry;
- Shared ambulance bay / patient transport bay;
- Separation of vehicles and pedestrians;
- Shared work stations with minimal cellular offices;
- Shared consulting rooms within Wellness Centre;
- Spaces operate at capacity with alternative areas to cater for surge capacity;
- Ensuring the SoA areas are achieved;
- Clustering services together into the identified functional zones;
- Providing a 24hr zone (ED and IPU) and 12hr zone (Wellness Centre and Clinical Support Areas);
- Continuity of services adjacent the construction zone;
- Ensuring infrastructure is put in place to service the facility;
- Minimisation of travel and engineering as well as circulation within units; and
- Facilitate and integrate service and coordination between different units and services.

The Project has adopted the HI systemised design approach, which includes such initiatives as functional adjacencies and efficient operational flows. The HI Expert Reference Group (ERG) reviewed the Project on 13 March 2019 and provided feedback for the Project Team to consider as the design is developed further.

Refer to the to the Master Plan and Functional Briefs in Appendices 2 and 3 respectively for further detail regarding the Design Planning Principles.

2.6.3 Schedule of Accommodation

A summary SoA is provided below for reference. Detailed SoAs are included as an appendix to the Functional Briefs which are found in Appendix 3.

Department	Nett (m2)	Circulation (m2)	Circulation %	GDA m2
Administration	24	6	25%	30
Wellness Centre	653	209	32%	862
Health Information	16	2	15%	19
Emergency Department	196	78	40%	274
Inpatient Unit	852	324	38%	1,176
Birth Unit	inc ab	inc ab	inc ab	0
Front of House	164	41	25%	205
Medical Imaging Unit	162	60	37%	221

Day Surgery Procedure Unit	334	127	38%	460
Pathology Unit	94	24	25%	118
Pharmacy	inc in IPU			
Non-clinical Support	167	28	17%	322
Staff Accommodation	300	30	10%	0
Subtotal	**2661**	**899**	**34%**	**3,687**
Travel & Engineering				848
GFA Total				**4,535**

Table 13: Summary Schedule of Accommodation

2.6.4 Furniture, Fixtures and Equipment

The FFE Schedule will be further developed during the Schematic Design phase and finalised during the Design Development phase of the Project, through the guidance of an FFE Committee and with the assistance of a dedicated FFE Coordinator from the MLHD.

The main principles underpinning the FFE Schedule are:

- Budget allowances comprise $2.27m for FF&E, ICT and MME. The procurement of the CT scanner has not been included in the project budget. The MLHD are currently developing a strategy for the CT scanner for the Project; and
- The Artwork Strategy will be development as part of the Design Development Phase.

2.6.5 Information, Communication and Technology

The ICT Strategy for THR has been included in Appendix 19 and will be further developed as part of Schematic and Detailed Design, by both the Project Team and MLHD ICT Team.

Project budget at Concept Design stage is based on a m^2 rate. The ICT budget forms part of the FFE, MME and ICT budget, for which there is an allowance of $2.7m.

The Project's ICT Strategy has been prepared in line with HI and LHD Design Principles, the Blueprint for eHealth and the MLHD's ICT strategic roadmap and outlines the following:

- The ICT strategic vision and strategic principles governing the THR project;
- The Core ICT infrastructure;
- The Service Delivery Platforms;
- Service Delivery System application; and
- Operational Processes.

The structure of the ICT Strategy is shown in Figure 10 below:

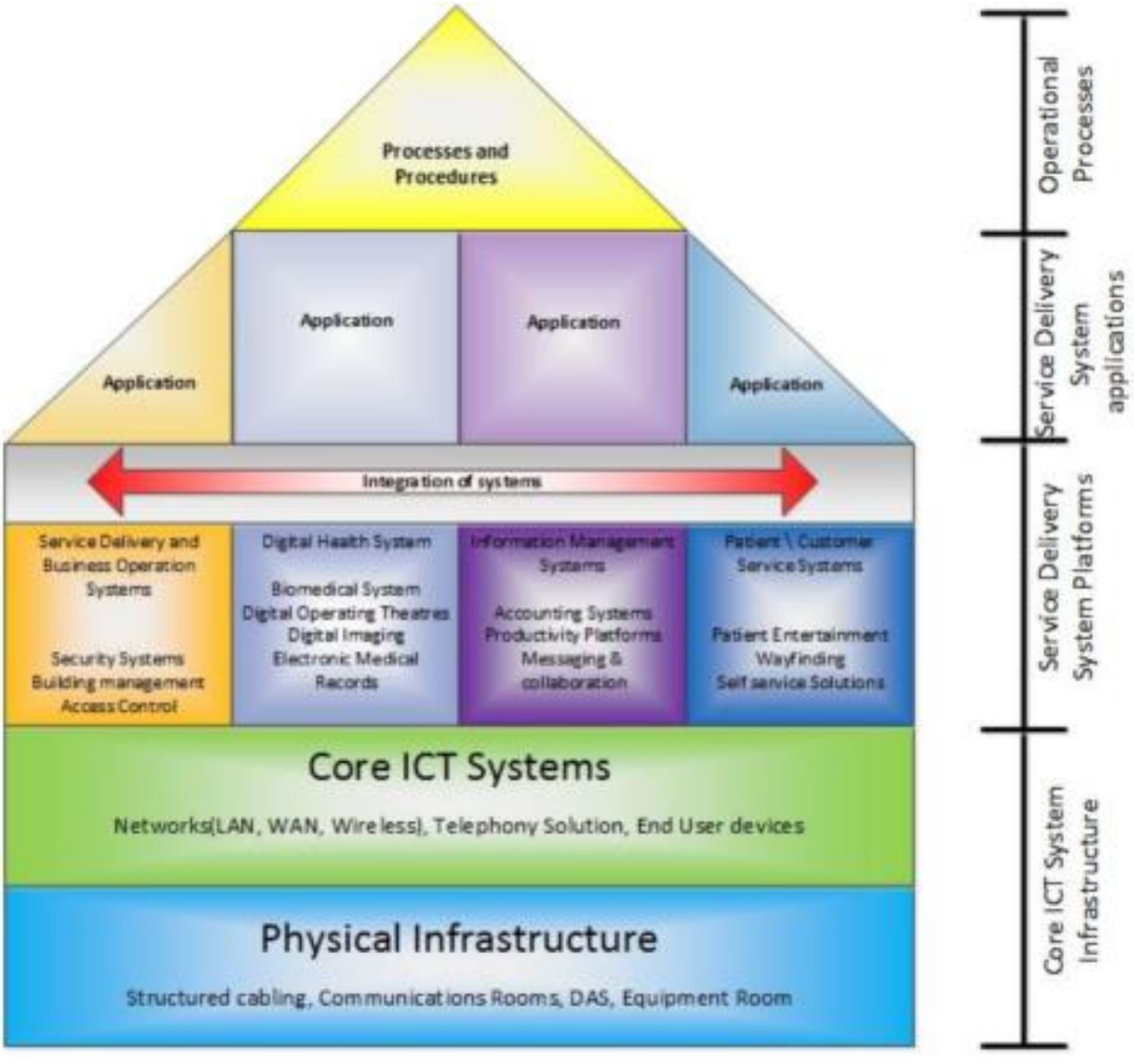


Figure 10: ICT Strategy Structure

3 Costs and Funding

3.1 The Financial Case

The Estimated Total Cost (ETC) of the Project is $50m, based on a gross floor area (GFA) of 4,535sqm.

In the Financial Case, the Base Case (Option 1), Option 2 and the Preferred Option (Option 3) are considered as follows:

Option	Description
Option 1 **ETC: $1m**	**Base Case** • Keep safe and operating.
Option 2 **ETC: $50m**	**A mix of new build and minor refurbishment to meet service statement need** • Construction of a new purpose-built facility to accommodate inpatient, emergency and ambulatory care services. • Undertake minor refurbishment to the existing community health /mental health /staff accommodation building (Building 3) and the existing renal dialysis demountable building (Building 7). This would likely result in continued inefficient utilisation of office accommodation space and poor functional relationships, with more travel distances to clinical services resulting in less integration.
Option 3 **ETC: $50m**	**A full new build to address service statement need** • Construction of a new purpose-built facility to accommodate all inpatient, emergency, ambulatory care, as well as community health, mental health and renal dialysis services. • Exploring alternative non-capital solutions for staff accommodation.

Table 14: Summary of Options

The refurbishment of the existing buildings combined with some new construction was considered as an option in an IDT developed in December 2017. The cost of this option comprising of 80% refurbishment and 20% new construction was calculated at $61.5M. There was a cost premium associated with a prolonged program, and a staging costs associated with refurbishing an operational health facility. This exceeded the cost of the complete replacement and demolition of the existing buildings. This option was therefore was excluded from further consideration as part of the options development process.

3.1.1 Capital Cost

The Capital Cost Plans of Option 2 and Option 3 were prepared by Concept 2 Reality (C2R) consulting based on the final SoA.

- Under Base Case (Option 1), it is assumed that $1m capital maintenance in 2020/21 will be required, given the existing asset condition and in order to ensure safe service delivery.
- Under Option 2, future capital cost is assumed in regard to the replacement of the existing mental health/staff accommodation building and renal dialysis demountable unit. The replacement cost is estimated at $8m in 2032/33.
- Under Option 3, it is assumed that there will be no future capital cost for the existing assets as all existing assets are to be demolished. All capital cost will be allocated to the construction of the new facility.

Table 15 and 16 summarise the ETC and Capital Cash Flows for the above options respectively.

Capital cost	Total Estimated Costs	Cost escalation	Capital cost excluding escalation
Option 1 - Base Case	1.0	Nil	Nil
Option 2	50.0	1.8	48.2
Option 3	50.0	1.8	48.2

Source: C2R consulting.

Table 15: Estimated Total Costs ($m)

Capital cost	Total	2018/19	2019/20	2020/21	2021/22	2022/23
Option 1 - Base Case	1.0	-	1.0	-	-	-
Option 2	48.2	2.1	6.1	20.2	12.3	7.6
Option 3	48.2	2.1	6.1	20.2	12.3	7.6

Source: C2R consulting.

Table 16: Capital Cost Cash Flow $m (excluding escalation)

Capital Costs ($)	Total ($)	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
Building costs	30,760,000	-	-	3,451,160	18,916,351	8,392,489	-
Professional fees, Authority fees, LHD/HI Costs, commissioning	7,620,000	-	2,115,419	2,612,476	1,245,063	1,622,042	25,000
Contingencies	7,550,000	-	-	-	-	-	7,550,000
FF&E & ICT	2,270,000	-	-	-	-	2,270,000	-
Escalation	1,800,000	-	-	201,953	1,106,939	491,108	-
Total project costs	**50,000,000**	**-**	**2,115,419**	**6,265,589**	**21,268,353**	**12,775,639**	**7,575,000**
Total ETC excl. escalation	**48,200,000**	**-**	**2,115,419**	**6,063,636**	**20,161,414**	**12,284,531**	**7,575,000**

Table 17: Capital Cost Summary (nominal $)

3.1.2 Capital Funding

The NSW Government is the sole source of funding, contributing $50m over the course of 5 years.

Funding sources ($)	Total ($)	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
Consolidated Funding (on AAP)	50,000,000	-	2,115,419	6,265,589	21,268,353	12,775,639	7,575,000
Commonwealth Funding	-						
Asset Sales	-						
Local Funding sources (please specify)	-						
Other Funding sources (please specify)	-						
Total contributions	**50,000,000**	**-**	**2,115,419**	**6,265,589**	**21,268,353**	**12,775,639**	**7,575,000**

Table 18: Proposed Capital Funding Source

The Capital Investment Strategic Plan (CISP) allocation for a project represents a reservation on the forward capital program. It is reserved at a point in time prior to undertaking detailed planning for the project. The capital cash flow is based on the information known to date. This cash flow will continue to evolve as the planning continues and cost estimates are confirmed. It differs from the CISP cash flow for this project. As part of the Total Asset Management process, the Ministry of Health and Health Infrastructure will undertake portfolio level analysis to ensure that final allocations are as closely aligned to project requirements whilst staying within the approved Capital Program Limits.

TUMUT	Total	2018-19	2019-20	2020-21	2021-22	2022-23
Draft 2018-19 CISP cash flow (current as of 21 Feb 2019)	50,000		3,500,000	5,000,000	30,500,000	11,000,000
Preferred option cash flow	50,000	2,115,419	6,063,636	20,161,414	12,284,531	7,575,000

Table 19 Project Cash Flow

3.1.3 Recurrent Costs

As detailed in the Financial Impact Statement (FIS) in Appendix 9, the operating cost estimates are based on the input-based budget / Net Cost of Services (NCOS) approach. Any projected increase in the NCOS due to the Project is assumed to be funded on the basis of Small Rural Hospitals Funding Methodology.

The operating cost projections under Option 3 are referenced from the FIS which has been developed by the MLHD. Additional operating cost is associated with staffing impact (1.89 FTE) of new renal chairs within the Wellness Centre, CT scanner lease and running costs (which are offset by private patient fees) and recurrent repair, maintenance and replacement (RMR).

Option	2018/19 Current	2022/23	2026/27	2031/32
Option 1 - Base Case	10.1	10.1	10.1	10.1
Option 2	10.1	10.9	10.9	10.9
Option 3	10.1	10.8	10.8	10.8

Source: Option 3 MLHD. Option 2 is high-level estimates only.

Table 20: Operating Costs excluding RMR, depreciation ($m)

For Option 2 and Option 3, recurrent RMR is based on 1.5% p.a. of the assets' replacement value. Under Option 2, it includes the recurrent RMR of the future replacement work post 2032/33 (~$0.12m pa).

Of note; under the Base Case (Option 1) additional recurrent maintenance costs to keep the existing facilities safe and operating is $0.1m p.a. (For example; to address the frequent plumbing issues on site.)

Option	2018/19 Current	2022/23	2026/27	2031/32	Post 2032/33
Option 1 - Base Case	0.33	0.43	0.43	0.43	0.43
Option 2	0.33	0.80	0.80	0.80	0.92
Option 3	0.33	0.75	0.75	0.75	0.75

Table 21: Recurrent RMR ($m)

While the THR provides a contemporary and expanded clinical capacity, it will also provide revenue and efficiency opportunities that will ensure that operational costs remain affordable into the future.

Key cost and revenue assumptions of the FIS are:

- All figures are at 2018/19 dollars values;
- There will be additional expenses associated with new satellite renal dialysis chairs:
    - Labour costs –increase of 1.89 FTE at a cost of approx. $163,000.
    - Goods and services – estimated to be $140,000.

- Costs for new CT scanner:
  - Labour – minimal due to the belief the existing staffing level will be able to absorb increased activity.
  - Lease costs including maintenance contract $151,000.
  - Operating costs including special services $235,000 after factoring in savings from the current model of scans provided by a private practice in Tumut.

- Lease of a four-bedroom house for staff accommodation from January 2022 for $22,000 including outgoings;
- RMR of new facilities is assumed at 1.5% of asset replacement value or circa [$0.75m], in line with the MOH's long term asset maintenance benchmarking objective. The incremental RMR is ~$0.42m;
- Depreciation is based on economic asset lives of 40 years for buildings at 2.5% p.a. of asset replacement value; and
- No changes to the patient fees, i.e. stay constant at 2018/19 level, however other revenue/user charges are anticipated to increase by approx. $0.5M due to privately referred CT outpatients.

3.1.4 Total Quantifiable Costs

The key costs outlined above have been quantified in present value terms over a 20-year analysis period for each of the assessed options. The results of this assessment are presented in Table 21.

Present Value (PV) (20 Years @ 7%)	Base Case	Option 2	Option 3
Capital Costs	0.9	39.1	39.1
Operating Costs excl. RMR	106.9	113.0	112.6
Recurrent RMR	4.3	7.5	6.8
Life Cycle Capital Maintenance Costs	-	3.8	3.6
Future cost to replace Building 3 & 7	-	3.2	-
Total Costs	**112.1**	**163.4**	**162.1**
Incremental to Base Case	**-**	**54.4**	**50.0**

Table 22: Total Quantified Costs against Base Case over 20 Years ($m, 2018/19)

3.2 Benefits Realisation

The MLHD have prepared a Benefits Realisation Plan (Appendix 13) concurrently with the Change Management Plan (Appendix 14).

The expected outcomes and project benefits are:

- Improvement in safety, models of care and better patient flows through modernisation of the current infrastructure and overall improvement of interdepartmental flows, adjacencies, and functionalities;
- Maintaining existing serviceability and improved service efficiency for inpatient, emergency and non-admitted patient services (outpatient, community care, and ambulatory care) to meet the projected future service demand to 2036; and
- Improved accessibility for patients who would have otherwise travelled to other hospitals to receive treatments.

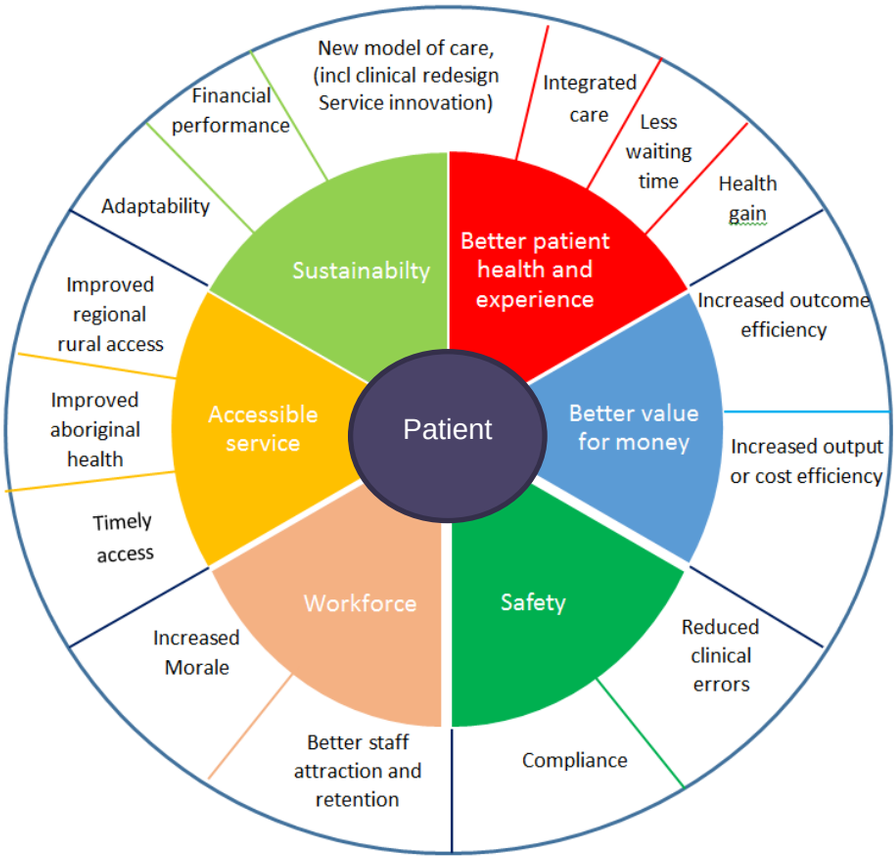


Figure 11: HI's Benefit Conceptual Framework

Table 22 below provides a summary of the performance measures and targets that will be used together with the MLHD goals as targets for the Project. These measures have been mapped to the above *Health Infrastructure Benefits Realisation Framework* and will be monitored and reported through the project framework.

Benefit Type/ Outcome	Benefits	Indicators and Measures
Better Patient Health and Experience	Connected Care Experiences for better health & wellbeing	Physical number of additional clinical treatments spaces in the ambulatory, inpatient and emergency zones and inclusion of quiet room for families
Better Patient Health and Experience	Increased recognition of Tumut Hospital as a hub site, due to; improvements to facilities & clinical capacity	Consumer/patient survey as part of post occupancy evaluation Patient Experience Survey following treatment/inpatient episode Number of complaints/compliments Improved public relations and community promotion of new spaces
Better Patient Health and Experience	Improved food service delivery model. Which may, decrease food waste, improve nutritional consumption of food	Percentage of patient consumption & satisfaction of food

Benefit Type/ Outcome	Benefits	Indicators and Measures
Accessible Services	Increased engagement with health programs and services by Aboriginal consumers	Proportion of separations for Aboriginal patients to increase
Accessible Services	Additional access to services through improved service delivery options	Increased activity documented in CHOC and EMR data shown in performance data
Sustainability	Improved efficiencies when compared to current clinical service delivery	Cost per non admitted activity (CHOC)
Sustainability	Efficiencies in building infrastructure	Report and monitor on all energy consumption and asset operating cost (utility costs to be calculated against patient volumes)
Better Value for Money	Reduced transport costs	Patient often travel to Wagga for services. Post commission, MLHD will be able to measure the decline in patients seeking service in Wagga, who live in the Tumut Catchment area
Better Value for Money	Improved ability to create new partnerships	Number of new services delivered at the hospital Increase in student numbers Increase in internal training opportunities
Workforce	Improved workforce culture, morale, satisfaction, recruitment and retention	Staff survey participation and satisfaction indicators
Safety	Improved patient and staff safety	IIMs Reports (in regard to safety & clinical incidents)
Safety	Improved infection control outcomes	Number of patients with flagged infection occupying single rooms

Table 23: Summary of Key Benefits, Performance Measures and Targets

3.3 The Economic Case

HI's Business Strategy Unit (HI BSU) has undertaken a Cost Benefit Analysis of the THR, provided in Appendix 10. In accordance with the *NSW Government Guidelines for Cost Benefit Analysis'* issued by NSW Treasury in March 2017 (TPP17-03) and the *NSW Health Guide to Cost-Benefit Analysis of Capital Projects* (GL2018_021), the report presents the options that have been considered and the cost-benefit analysis of those options.

A detailed breakdown and explanation of the following elements is found in the CBA at Appendix 10:

Key Evaluation Assumptions	Refer to Section 4.3, Appendix 10
Assessment of Costs; Quantifiable & Non-quantifiable	Refer to Section 5, Appendix 10
Assessment of Benefits	Refer to Section 6, Appendix 10
Findings and Results of CBA, including BCR	Refer to Section 7, Appendix 10
Sensitivity Analysis	Refer to Section 8, Appendix 10
Conclusion and Recommendation	Refer to Section 10, Appendix 10

Table 24: Key Sections of Cost Benefit Analysis

3.3.1 Assessment of Costs

The present value of the incremental cost of Option 2 and Option 3 as compared to the Base Case, Option 1, is shown below, noting the average annualised Life Cycle Capital Maintenance (LCCM) costs is assumed to the 1% of the ETC from construction completion and new service commissioning.

Present Value (PV) (20 Years @ 7%)	Base Case	Option 2	Option 3
Capital Costs	0.9	39.1	39.1
Operating Costs	106.9	113.0	112.6
LCCM Cost	-	3.8	3.6
Total Costs Incremental to Base Case		**54.4**	**50.0**

Table 25: Total Quantifiable Costs against the Base Case ($m, 2018/19 dollars, Present Value over 20 Years @ 7%)

3.3.2 Assessment of Benefits

A summary of the direct and indirect benefits of the assessed options is provided in the below table:

Description	Benefits	Option 1 Base Case	Option 2	Option 3
Direct	Improved patient health outcomes as a result of modernisation of facility and enhanced functionality to deliver inpatient services.	×	✓	✓
	Improved patient health outcome from a new renal dialysis unit	×	✓	✓
	Avoided travel costs	×	✓	✓
	Residual assets value	×	✓	✓
Indirect	Improved access to services	×	✓	✓
	Enhanced amenity and safety for patients/staff	×	✓	✓
	Improved service integration	×	✓	✓
	Development of culturally appropriate spaces	×	✓	✓

Table 26: Options comparison - Assessment of Benefits

Quantifiable Benefits

The following quantifiable benefits have been identified:

- Improved patients' health outcomes as a result of modernisation of facility and enhanced functionality to deliver inpatient services;
- Improved patients' health outcomes as a result of new renal dialysis unit;
- Avoided costs as a result of expanded ambulatory care services;
- Avoided travel costs; and
- Residual value of new assets.

Based on the approach detailed in Section 6 of the CBA (Appendix 10), results of the total quantifiable benefits over a 20-year analysis period associated with each project option are presented in Table 26.

Present Value (PV) (20 years @ 7%)	Base Case Option 1	Option 2	Option 3
Improved Patients health outcomes			
- **Inpatient services**	369.8	412.9	412.9
- **Renal dialysis (new service)**	-	3.6	3.6
Avoided costs – Ambulatory / NAPS	-	2.6	2.6
Avoided travel cost	-	0.01	0.01
Residual value	-	5.2	3.6
Total	**369.8**	**424.3**	**422.7**
Incremental to base case	**N/A**	**54.5**	**52.8**

Table 27: Quantified Benefits over 20 Years ($m, 2018/19 dollars)

Qualitative Benefits

The following qualitative benefits have been identified:

- Improved access to health services;
- Improved amenity benefiting the safety for patients and staff;
- Improved facility functionality to support the implementation of a contemporary model of care; and
- Potential improvement in staff attraction and retention.

3.3.3 CBA Results

Based on the quantitative analysis of the costs and benefits of the Project, the results of the CBA are presented in Table 27. Results are presented incrementally to the Base Case.

Present Value (PV) (20 years @ 7%)	Option 2	Option 3
Incremental costs		
Capital costs	38.2	38.2
Operating costs (excluding maintenance costs)	6.1	5.7
Recurrent replacement, maintenance and repair (RMR) costs	3.2	2.5
Life-cycle capital maintenance costs	3.8	3.6
Future cost to replace Building 3 & 7	3.2	-
Total incremental costs	**54.4**	**50.0**
Incremental benefits		
Improvement in patient's health outcomes:		
• Inpatient care (acute and subacute)	43.1	43.1
• Renal dialysis	3.6	3.6
Avoided costs – NAPS	2.6	2.6
Avoided travel costs	0.01	0.01
Residual value	5.2	3.6
Total incremental benefit	**54.5**	**52.8**
Incremental NPV	**0.1**	**2.8**
BCR	**1.00**	**1.06**

Table 28: Key Results, Incremental to Option 1 (Base Case) ($m)

The CBA results indicate that both investment options will generate positive Net Present Values (NPV) and Benefit Cost Ratios (BCR).

Option 3 will generate a higher NPV and BCR than Option 2 due to:

- No requirement to upgrade/replace Building 3 and 7 in the future; and
- Lower operating costs related to savings in front of house staff, facility maintenance costs and recurrent RMR.

Qualitatively, Option 3 is expected to generate greater amenity better staff and patient safety, and better facility connectivity than Option 2.

Under Option 3, the net benefits of the Project would be generated from:

- Improved patients' health outcomes as a result of a better integration of health service and enhanced infrastructure functionality and layouts
- A range of unquantified net benefits including:
    - Improved community access to health services, in particular CT and renal dialysis.
    - Improved patient and staff safety and amenity.
    - Expected improvement in staff attraction and retention rates.
    - Improved operating efficiency as a result of overall improvement in infrastructure and service delivery.

4 Sustainability

4.1 Social

In line with the *NSW State Health Plan,* the THR project will create a more connected health system across the primary and acute settings that will not only improve patient outcomes but will assist in reducing unnecessary hospitalisations and emergency department presentations and create a more financially sustainable health system for the future.

The stand-out social benefits of this Project are:

- Increased accessibility to services by increasing the self-sufficiency of service provision at Tumut;
- Improved patient outcomes through holistic care and integrated service delivery at the Wellness Centre; and
- Improved employee wellbeing and better service delivery as a result of improved functional adjacencies and more efficient operational flows in the new facility.

The THR project will deliver to the community a compliant and contemporary facility, necessary to meet the health needs of the current and future population. The new facility will enable the provision of self-sufficient and sustainable services that align with contemporary and integrated models of care by improving clinical functional relationships and operational flows.

The THR will change how services are provided to patients by focusing on delivering value to the patient in a “one stop shop” through integrated services at the Wellness Centre. This Project will improve health outcomes to the community, particularly to the ageing population of the Tumut Catchment by providing access to integrated health care services closer to home, thereby dramatically improving the patient experience.

Through the delivery of integrated services in a holistic manner, the Wellness Centre will facilitate the implementation of long-term lifestyle changes for the community to better meet their future health needs and improve patient health outcomes.

Impact on Patients

Patients treated at the expanded THS will experience a reduction in disability burden (i.e. pain and suffering). Healthier patients are likely to have better relationships with their family members and other members of the community. Patients and their families will also experience the aesthetic improvements and increased comfort of the redeveloped hospital.

Impact on the Community

The Project will enhance the capacity of THS and the broader MLHD network to meet the growing health service needs of residents in its catchment areas. This will ensure continued equitable access to high-quality and timely healthcare, particularly for vulnerable segments of the population such as ATSI community and those from a low socioeconomic background.

Impact on the Workforce

Improvements in the model of care and functional relationships of the facilities, as well as access to modern equipment, will also make THS a more desirable workplace for hospital staff. This will raise staff morale and productivity, as well as increase staff retention. The Project will assist LHD in filling vacant staff positions (particularly for specialist roles) by making it easier to attract applicants from outside the region.

4.2 Economic

In line with the strategic plan, the planning of the THR has been undertaken from a district wide perspective which supports the viability and sustainability of services delivery identified within the Preferred Option. The

THR has a proposed $50m ETC. The *NSW Rural Health Plan* sets out the vision to have a greater integrated service delivery approach across rural NSW. The *MLHD Strategic Plan 2016-2021* establishes a focus on wellness and an interconnected system of healthcare. The capital investment in this new facility has considered the efficiencies and enhancements that will arise from the Project. The efficiencies and enhancements that will arise are across the ongoing operational efficiencies and service delivery.

Impact on Patients

By improving the health outcomes of patients who would otherwise not be treated in the absence of the Project, the Project will enable their return to the workforce and community sooner than otherwise, thus raising labour productivity and economic output in the Snowy Valleys area.

Impact on the Health System

The Project is expected to deliver better value for money through implementation of a contemporary models of care and improved facility functional relationships

Improvements in the model of care and functional relationships of the facilities are expected to increase the quantity of health services that the hospital is expected to be able to supply for a given quantity of resources i.e. increase productivity by increasing technical efficiency. The improvements will also increase the efficiency with which the hospital manage and allocate its resources, thereby reducing the operating costs associated with supplying the increased outputs of health services.

Impact on the Community

By delivering a fit-for-purpose, contemporary and attractive facility, the Project will help ensure that its catchment area is viewed as a desirable region that offers a high quality of life, thereby assisting in the retention of existing residents and attraction of new residents to ensure economic vibrancy and sustainability.

Impact on the Workforce

Improvements in the model of care and functional relationships of the facilities, as well as access to modern equipment, will also make THS a more desirable workplace for hospital staff. This will raise staff morale and productivity, as well as increase staff retention. The Project will assist LHD in filling vacant staff positions (particularly for specialist roles) by making it easier to attract applicants from outside the region.

4.3 Environmental

The THR will deliver a modern facility that is efficient across its use of energy, waste, and water, and reduce its emissions in line with the *NSW Government Resource Efficiency Policy*. Further, the THR will utilise local businesses and trades during the construction phase which will create a positive impact on the local community and businesses.

The future design of the THR has also been undertaken with a view to minimise impact to the environment and/or improve the existing environmental conditions within the site. This involves developing an understanding of the impact of the expansion across key areas including but not limited to biodiversity, visual amenity, flooding, stormwater, noise and vibration, and soils.

Preliminary assessment indicates that any environmental impacts of the THR can be successfully managed. This Project is being planned on the existing THS campus and therefore will not impact any otherwise relatively undisturbed natural precinct.

5 Governance

The MoH established the Process of Facility Planning (PoFP) to provide a robust framework for procuring capital infrastructure across the NSW public health system. HI has adopted an approach based on the PoFP to facilitate project delivery. The alignment of the PoFP with the HI Phases and Parts is shown in the below diagram.

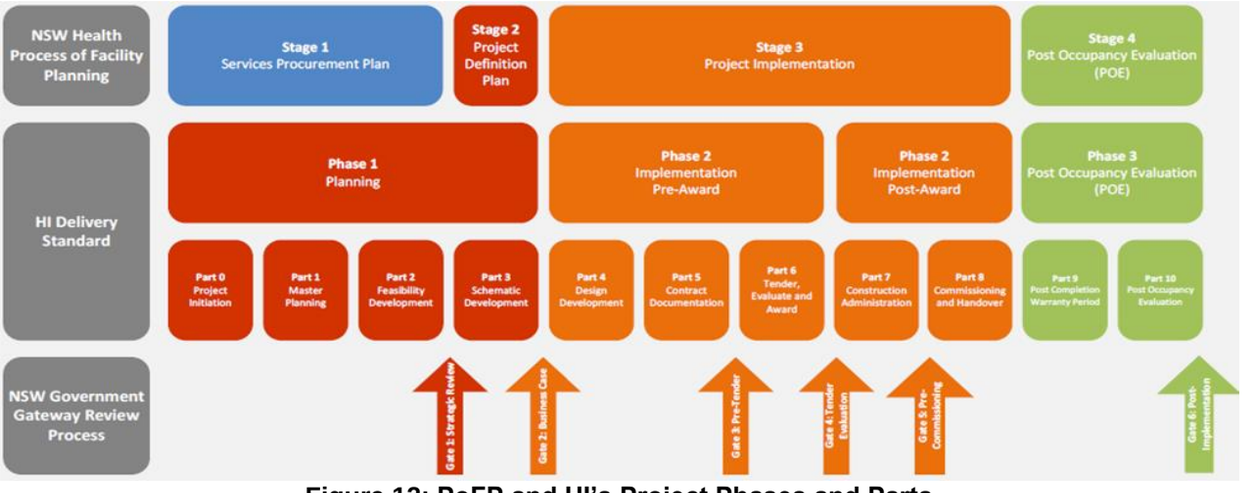


Figure 12: PoFP and HI's Project Phases and Parts

Each of the Phases and Parts are provided with a set of pre-agreed deliverables and milestones against which the implementation of the Project can be procured, controlled and measured.

The Project falls under the management and control of HI. The governance structure adopted for this Project is in accordance with the HI general standards for governance, governance committees and reporting structures. (Appendix 11). Proven structures and processes will be adopted to manage this Project, which will be similar to those applied to all other capital developments undertaken by HI.

5.1 Project Governance

The Project Governance Structure was established upon commencement of the Planning. Membership of the committees and/or their memberships will be updated as required to ensure the inclusion of relevant stakeholders at the appropriate level of governance. Any changes to the Governance Structure will be approved through the project governance process.

The following groups have been established, or are intended to be convened throughout the Project:

1. Executive Steering Committee (ESC)
2. Planning & Development Committee (PDC) (Planning)
3. Project Control Group (PCG) (Delivery)
4. Project Working Group(s) (PWGs)
5. Executive User Group (EUG)
6. Project User Group(s) (PUGs)

5.2 Project Delivery

As shown in the above diagram at Figure 12, HI's Project Delivery Framework comprises the following Phases:

HI Project Delivery Framework	
Phase 1	Planning
Phase 2	Implementation (Pre-Award)
Phase 3	Implementation (Post-Award)
Phase 4	Post-Occupancy Evaluation

Table 29: HI's Project Delivery Framework by Phase

Throughout the Planning Phase, MLHD involvement occurs via one or two roles:

1. Participation in Project Governance Committee(s), such as:
    - Planning and Development Committee (PDC);
    - Executive User Group (EUG); and
    - Project User Groups (PUGs).

2. Responsibility for documentation deliverables to be included in the Business Case, such as the following Project Plans:
    - Change Management Plan
    - FFE Plan
    - ICT Strategy
    - LHD Project Resource Plan
    - Workforce Plan
    - Benefits Realisation Plan
    - Communications & Engagement Plan

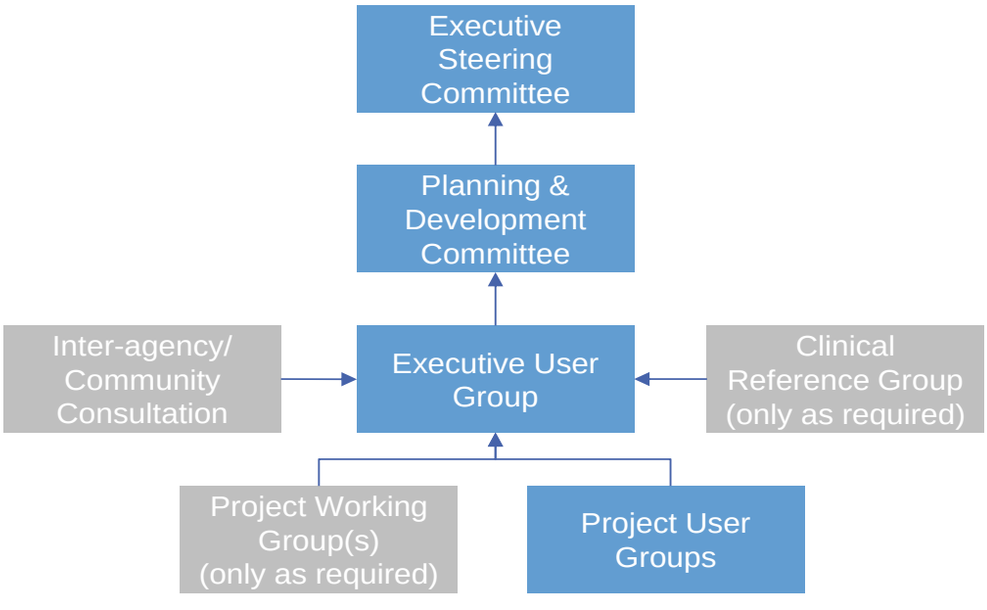


Figure 13: Project Governance Structure

As the Project progresses through to the Delivery Phase, the Project Governance Structure will be revised to ensure that the Project is successfully carried through to completion in accordance with HI's standard governance arrangements.

During the Delivery Phases, MLHD involvement will include:

1. Participation in Project Governance Committees, such as the:
    - Project Control Group (PCG);
    - Project User Groups (PUGs); and
    - Project Working Group(s) (PWGs).

2. Implementation of the above Project Plans.

In line with the governance structure identified above, a number of PWGs and PUGs will be established during the course of this Project.

Typically, PWGs are split into the following committees, where required:

- FFE Control PWG
- Communications and Engagement PWG
- Aboriginal Liaison PWG
- Change Management PWG
- ICT PWG
- Commissioning and Operational Planning PWG
- Systems and Equipment – Major Medical PWG
- Transition Logistics and Decant PWG

On the THR project the following PUG's have been identified and are currently being implemented:

- Emergency Department
- Inpatient Unit
- Day Surgery/ Theatre
- Back Of House
- Front of House
- Wellness Centre
- Medical Imaging

5.2.1 Project Delivery Team

The MLHD Project Resource Plan (Appendix 7) has been developed in consultation with the MLHD Executive to ensure the required LHD resources are made available or procured in a timely manner. It also notes that in some instances it may be appropriate to appoint an external consultant to support the LHD for the specific deliverable if LHD resources are not readily available to support the Project's deliverable and/or activity.

Planning Phase

For a comprehensive summary of the MLHD's resourcing requirements and commitments throughout the Planning Phase, please refer to the 'Planning Phase - Key Deliverables and Associated Roles and Responsibilities' table in Part 3 of Appendix 7.

The table below summarises the MLHD's anticipated resourcing commitments throughout the Implementation Phase. Further details regarding the requirements and role of these resources can be found in the specific Project Plans, included as Appendices to this Business Case.

LHD Resource	Individual/s	Anticipated Time Commitment by Part
General Manager Operations (Redevelopment Exec Lead)	Carla Bailey	
Project Officer	TBA	Under Recruitment
Change Manager	TBA	Under Recruitment
Communications Officer	Fiona Halloran	Engaged during Planning and will continue through to Part 9.
ICT Project Officer	Sheree McIntyre	Engaged.
FFE Project Officer	TBA	TBA: Role may be completed by Change Manager, who will be engaged on a full-time basis.
Transition and Move	TBA	TBA: Role may be completed by Change Manager, who will be engaged on a full-time basis.

Table 30: MLHD Anticipated Resourcing Requirements

Implementation Phase

By the time the Implementation Phase has commenced, the majority of the Project Plans will have been developed by the MLHD. Each Plan should identify the LHD resourcing required for its implementation.

Key activities during this Phase include implementation of the following:

- Benefits Realisation Plan
- Change Management Plan
- Communication and Engagement Plan
- Workforce Plan
- FFE Plan
- ICT Strategy.

5.2.2 Master Programme

A detailed Master Programme is included at Appendix 18. A summary list of key milestones and activities is provided below:

- Business Case approved by MoH – June 2019
- Planning Approval (REF) Received – August 2019

- Tender Issue - September 2019
- Tender Evaluation and Award - October/ November 2019
- Construction Commences - December 2019
- Operational Readiness - December 2021
- Construction Completion - June 2022

5.2.3 Project Delivery and Contractor Procurement Strategy

In order to mitigate program risk and meet the planned construction commencement by the end of 2019, a two (2) stage delivery methodology, delivered via a single contract has been assessed as being the most suitable delivery and procurement strategy for the Project. The scope will include the following:

1. Construction of enabling works with design finalisation as required (Design Finalisation and Construction); and
2. Design finalisation and construction of main works based on nominal 70% DD documentation and novation of selected Capital consultants.

By using this delivery methodology, a number of significant project risks will be reduced as outlined below:

- Reduced duplication of site mobilisation costs;
- Reduced escalation costs through issue of single LOA in 2019 rather than separate LOA following completion of main works CD;
- A higher value contract may attract capable contractors willing to work in rural settings;
- Reduced impact of delay, with one contractor delivering full scope; and
- Improved project continuity through DD and CD reducing the risk of scope variations through novation of consultants.

5.2.4 Town Planning Strategy

In consultation with the planning consultant, a REF has been recommended as the most appropriate planning pathway for the Project. The REF process will be the most streamlined planning pathway option given that approval for the entirety of the works can be granted under the one single REF, thereby avoiding the requirement for a CDC.

The REF planning process (from commencement of documentation preparation to approval) can be completed in approximately 3 months. The alternative planning pathway is an SSD Application. This would likely take approximately 3 to 4 months to prepare, and a further 6 to 8 months for a determination to be made by the Department of Planning. Therefore, the SSD pathway has been identified as unsuitable for this Project.

6 Risk Management

6.1 Risk Management Plan

The Risk Management Plan (RMP) for the THR project provides a risk management framework which demonstrates the process for identification, assessment and mitigation management of project risks. The purpose of the RMP is to plan ahead for any foreseeable risks that are predicted to cause negative impact to the Project so that the impacts are controlled to be minimised or mitigated.

The RMP follows principles and guidelines provided in ISO 31000:2009 for managing risk on the basis that risk management is an on-going process throughout the life cycle of the Project including operation and management of the asset post construction.

A comprehensive Risk Register, detailing the risks identified through the Risk Management Workshop with the EUG and further updated during the development of the Concept Options is included in Appendix 12. The project risks were considered whilst finalising the project budget to identify and test that the identified risks will be manageable should they be realised. For example;

- Hazardous material and contamination of material during civil works;
- Hazardous material and contamination of material during demolition of the exiting building; and
- Temporary and relocation of services such as the heating hot water systems and main distribution board.

6.2 Risk Register

Risk Management Plan and Register are live documents and have been endorsed by the PDC. The top 7 key project risks are identified as follows:

Risk Category	Risk Description	Mitigation Strategy	Risk Rating
Change Management	New models of care (and New Ways of Working) are not implemented effectively, leading to service delivery of workforce issues.	Change management strategy implemented and Change Manager to be engaged. Presentations and education of staff and patients. Assisting key staff members with opportunities to visit hospital sites where change management has successfully been implemented. Ongoing engagement post-handover and commissioning. Workflows for each department including patient check-in and movement between departments to be reviewed and updated to reflect new models of care and department adjacencies.st-handover and commissioning.	Medium
Program	Delay to the delivery of the Project due to planning/ procurement / construction delay	Detailed Project Plans, which are tracked and managed. Commence selective Early and Enabling Works during Planning Phase where possible. Development and approval of a robust procurement strategy. Ongoing review with Project Team and stakeholders. Identify where program may be accelerated if required.	Medium

Risk Category	Risk Description	Mitigation Strategy	Risk Rating
		Allow for contingency within the Master Program.	
Communication, Stakeholder & Community Management	Failure to engage with the community including the aboriginal community	Ongoing involvement of and consultation with the Aboriginal Advisory Group. Broader stakeholder involvement. The three groups need to be engaged independently with a project target of a single final outcome, or outcomes that are acceptable to each group.	Medium
Community expectations regarding project scope	Failure to engage or effectively communicate regarding project scope, in particular the ambulance station	Ongoing communications with the community and councillors.	Medium
Construction	The THR results in service disruption to the existing hospital	Contractor to forecast upcoming Disruption Notices to facilitate lead time for MLHD engineers to review and assess implications. Project Team will develop a detailed project delivery strategy in close consultation with all stakeholders which considers early responses to risk items. Participation by all key stakeholders at regular and frequent Disruption Notice meetings. Review and refresh the Tumut Hospital Business Continuity Plan; and Develop detailed staging plans, in partnership with the relevant stakeholders.	Medium
Clinical care and public safety	Relocation of helipad	Working group established with MLHD & NSW Ambulance to develop operational strategies to manage the transfer process during the construction period.	Medium

Table 31: Top 7 Key Project Risks

7 Stakeholder Engagement

7.1 Stakeholder Identification & Analysis

This Project extends beyond asset delivery to deliver sustainable health services at THS. It includes both the delivery of contemporary physical infrastructure and improved models of care and service delivery. The support of a parallel and inclusive change management and associated stakeholder engagement program is critical to ensuring the Project achieves its full potential of service improvement and modernisation. This process requires the support and demonstrated leadership of MLHD and clear ownership by the MLHD and THS Executive in consultation with all stakeholders.

The planning of THR is running in parallel with Griffith Base Hospital Redevelopment and is following the WWBH Redevelopment. The MLHD, HI and the Project Team have been able to implement the lessons learned from these other projects to enhance the planning for stakeholder, change and communications management for THR.

The key stakeholder groups which have been identified in the Project Governance structure are the Communications and Engagement Plan and Change Management Plan. These documents have identified key roles and responsibilities ensuring the development of the Business Case included relevant consultation with the appropriate stakeholders at each stage of the Project.

The comprehensive list of stakeholders can be found in Appendix A of the Communications and Engagement Plan, however of particular importance to the THR are the following stakeholders:

- Aboriginal Family Groups (of which there are several distinct groups within the Tumut Catchment);
- Tumut Catchment local community;
- Snowy Valley Council; and
- Tumut Hospital Auxiliary.

Bringing care closer to home is a key driver for the Project, with this in mind the Project seeks to create an awareness of the Project across the Tumut Catchment area and greater MLHD through a number of initiatives identified in Appendix 15:

1. Newsletter;
2. Regular updates to MLHD website;
3. A1 Display Board: Master Plan;
4. Frequently Asked Questions: Staff and Community;
5. Media Releases and Media opportunities;
6. Social Media: MLHD Facebook and Twitter;
7. Staff Emails;
8. Community and Staff Drop-in Information Sessions;
9. Status Master Plan display and suggestion box at Tumut Library; and
10. Dedicated Redevelopment email.

7.2 Stakeholder Management

The Communications and Engagement Plan (CEP) provided in Appendix 15, has identified a multitude of stakeholders that are impacted to varying degrees by the THR project. The approach to consultation and communication with these stakeholders has been planned and programmed, as set out in the CEP.

The CEP notes that the majority of stakeholders are excited to participate in the THR. Stakeholders, both internal and external are engaged and are already committed to consulting around the process, services and

infrastructure. It highlights the importance of maintaining this appetite for change at an optimal level in order to ensure the Project runs to time schedules and has a successful outcome.

The strategy for the engagement, approach and management of the expectations with key stakeholders has been developed and has been detailed in Section 2.7 and 2.8 of the CEP and Appendix A of the CEP.

The key headings in the stakeholder management table are summarised below:

- Category of relationship (i.e.; Active or Inform Only);
- Description of stakeholders;
- Risk category;
- Principal communications approach; and
- Current relationship to the Project.

8 Change Management

The following Change Vision has been identified and agreed by the relevant project stakeholders:

" Providing connected care experiences for better health and wellbeing".

8.1 The Scope of Change

The scope of change can be summarised by the following categories:

1. People (i.e.; patients, clinicians, visitors and suppliers);
2. Service (i.e.; clinical and non-clinical delivery);
3. Environment (i.e.; facility infrastructure or socio-economic outcomes);
4. Process (i.e.; business processes, workflows, policies and procedures);
5. Technology and Equipment (i.e.; MME, Telehealth);
6. Operations; and
7. Organisational (i.e.; redesign of ways of working).

Change management is an overarching strategy that is implemented throughout the duration of the project lifecycle. The Change Management Plan has been developed in conjunction with the EUG to ensure that the impact of change is fully understood by all project stakeholders, and the relevant actions and initiatives take place at the requisite stages.

Items 1-7 above are addressed throughout this Business Case, however they are highlighted and detailed in the Change Management Plan in Appendix 14.

8.2 Initial Change Impact Assessment (CIA)

An Initial Change Impact Assessment (CIA) has been carried out with the Project Team, with the change impact value being assessed as high-level. Below is a table detailing the Initial CIA:

Ref	Type of Chang	Indicator	Impact Value (*in line with HI Risk Ratings*)		Initial Change Impact Assessment Description (for Change Management Strategy for Business Case)
1	People	Likelihood of customers impacted	High (>95%)	5	All customers will need to access services through a new entry point, a navigate a new internal hospital layout. This is will require active wayfinging and education initiatives. There will also be changes in access throughout the construction phase.
2		Likelihood of patients or residents impacted	Medium (30-70%)	3	The redevelopment will result in a increase in service provision to the community (i.e. new CT service and expanded renal services).
3		Number of clinicians impacted	High (>95%)	5	All clinical staff onsite will be positively affected by the changes. The staff most impacted (in regards to work environment) will be the Community, Mental Health and Drug & Alcohol Staff, as they move towards new ways of working.
4		Number of non-clinicians impacted	Medium (30-70%)	3	The relocation of Non-Clinical Support Services, will result in all staff being affected (HealthShare staff, Asset Management, Linen Stores, HASA).
5		Likelihood executive stakeholders impacted (Minister, Chair, CEs, Directors GMs)	Medium (30-70%)	3	The GM will be most impacted, through the need to actively engage with staff onsite throughout the change lifecycle.
6		Involves union consultation or negotiation	Medium (30-70%)	3	This has been identified in the Communication Strategy. NMA & HSU will require further consultation throughout the Redevlopment.
7	Service	Clinical delivery affected	High (>95%)	5	New patient centred models of care, with a focus on improving access to Ambulatory Care services. There will be new models of care for Renal and Community & Mental Health and Radiology. Other clinical services will see improvements in both capacity and facilities.
8		Non-Clinical delivery affected	Medium (30-70%)	3	The relocation of Non-Clinical Support Services, will result in all staff being affected (HealthShare staff, Asset Management, Linen Stores, HASA). As HealthShare are currently providing My Food Choices, there will be reduced impact in regards to any changes in models of service delivery.
9	Environment	Extent of physical infrastructure impacted (i.e.. Facility)	High (>95%)	5	All existing buildings on the site will ultimately be replaced with new contemporary clinical facilities.
9		Extent of socio-economic impact	Medium (30-70%)	3	The scale of the change on the local and regional economy of Tumut will be limited in the context of some of the larger projects in the regions, such as Snowy 2.0 and the Visy factory.
10	Process	Requires the redesign of business processes / workflows	High (>95%)	5	There will need to be a re-engineering of the patient check-in and flow process for all departments. The workflows of each department will also change, as departments become more integrated. For Support Services, a number of new processes/workflows will need to be adopted (due to new location and facilities).
11		Requires the redevelopment of policies & procedures	Medium (30-70%)	3	Same as above: There will need to be a re-engineering of the patient check-in and flow process for all departments. The workflows of each department will also change, as departments become more integrated. For Support Services, a number of new processes/workflows will need to be adopted (due to new location and facilities).
12		Likelihood of affecting the information flow required within & outside the organisation communication	Low (<5%)	1	Communication management throughout the redevelopment is going to be critical to managing the change process.
13		Likelihood of impacting the methods and tools required to measure performance / KPIs and sustain change	Low (<5%)	1	Unlikely to impact.
14	Technology / Equipmen	Likelihood of affecting the systems and technologies people use; introducing medical equipment affecting ways of	High (>95%)	5	Will require additional technology solutions and management of these solutions. There is a change impact from the introduction and management of these solutions. For example, more flexible solutions for 'New Ways of Working', as well as more tele-health
15	Operation	Involves altering the way in which services will be delivered.	High (>95%)	5	The operations of all services will be impacted or altered due to the redevelopment.
16	Organisation	Likelihood to affect structures, jobs, roles and responsibilities	Medium (30-70%)	3	There may be some impact on current roles associated with the patient flow/check-in processes.. Additional FTE will also be required to support the increased number of clinical facilities.
17		Involves a shift in behaviour or the acquisition of new skills	Low (<5%)	1	Same as above. New skills required for Renal & CT Service.
18		Involves a shift in behaviour or the acquisition of existing skills	Low (<5%)	1	There may be some impact on current roles associated with the patient flow/check-in processes..
19		Involves the redesign of ways of working	Medium (30-70%)	3	There will be a number of staff that will have a change in work environment, or a process change in regards to work practices (in reference to 16, 17, 18, it is likely that these changes will be within staff skill set.
20	Others	Project timeframes increase the change management risk profile?	Low (<5%)	1	The Redevelopment program is condensed, however the commissioning program can be implemented in a staged way, to manage the implementation process. For example, not all departments need to move into the new building on the same day or week.
21		Degree of interdependence with other projects or programs	Low (<5%)	1	Other Redevelopments within the LHD, include Wagga, Griffith & number of MPS projects. However, the staff at Tumut are primarily site based, and are unaffected by other projects within the LHD.
22		Numbers, capability and availability of business resources to assist in managing the change into the Business	Medium (30-70%)	3	While local staff are largely unaffected by other projects in the LHD, a number of the LHD wide resources maybe assisting on multiple Redevelopment projects.
			Consolidated Scoring	**71**	
			Rating	**High**	**High**

Table 32: Initial Change Impact Assessment

8.3 The Management of Change

The HI Change Management Approach is based on proven change management methodologies supported by the HI service delivery model, as well as, the ACI Clinical Re-design Methodology and MoH Process of Facility Planning.

The HI Change Management Approach is a four-step process aligned to the Process of facility Management as demonstrated in the diagram above. The tools and templates seek to achieve consistency and transparency in the approach to change management across all HI capital works projects, with flexibility to its application depending on the scope and scale of change.

The following four step process is to be applied to the THR project in order to manage change successfully throughout the capital project lifecycle.

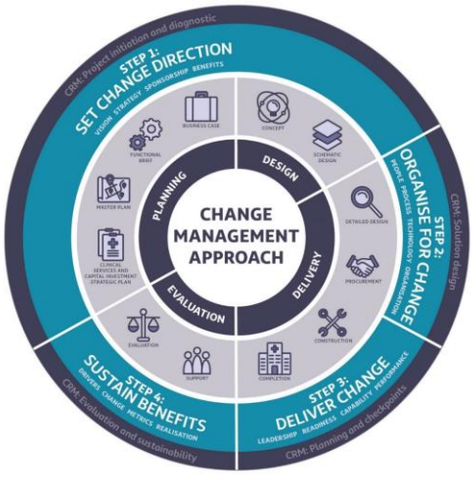


Figure 13: HI Change Management Approach

Figure 15: Four step Change Process

Figure 16 below represents the outcomes of the Change Management Strategic Workshop held on 4 March 2019 with the MLHD, THS, HI and the Project Team. The purpose of the workshop was to establish a vision and a roadmap for the overarching Change Management Strategy for the project. The following table identifies the current state and the future state that will be achieved by the Redevelopment:

Type of Change	Impact Areas	Current State	Future State
People	Patient	Fragmented services in dated accommodation, lack of space limiting clinical capacity.	Nominated services delivered in fit for purpose infrastructure. Expansion of selected services to partially meet growing demand as outlined in the Clinical Service Plan (CSP). Improved experience for patients in the new facility.
	Clinical Staff	Delivering services in cramped and dated settings not specifically designed for the specialty of care or contemporary models of care. poor functional relationships	Staff working in clinical areas that are fit for purpose and meeting the capacity requirements to provide safe and effective care. Improved experience for Staff, due to improved staff and patient zones, and ability to implement contemporary models of care.
	Non-Clinical Staff	Delivering services in dated settings with poor functional relationships and multiple buildings	Providing support in fit for purpose facilities, under one roofline.
Service Delivery	Clinical Delivery	Delivering services in dated settings not specifically designed for the specialty of care. Facilities do not allow for new contemporary models of care to be provided. poor functional relationships	Nominated services delivered in fit for purpose infrastructure that are flexible and able to meet service changes over time. Expansion of selected services to

Type of Change	Impact Areas	Current State	Future State
			meet growing demand as outlined in the CSP. New services to meet community needs, such as CT Service, satellite renal dialysis and outpatient clinics.
	Non-Clinical Delivery	Delivering services in dated settings and are 'disconnected' from the hospital buildings. New models not able to be accommodated for food services	Fit for purpose facilities, and easier service delivery.
Environment	Physical	Dated settings that are increasingly difficult to maintain. Services are provided out of 5+ dislocated buildings that are spread across the campus. At times, patients are required to walk between multiple buildings to access services.	A new facility that enables all services to be provided 'under one roof'.
	Cultural	Facilities are dated and feel 'clinical' and uninviting.	The Aboriginal community access services freely and are involved in activities and committees to improve access for Aboriginal people in an ongoing way
	Socio-Economic	Inequality in access to services. The need to travel for outpatient, level 3 renal dialysis services that could be delivered locally	Access to a broader range of clinical services within Tumut and reduced out of pocket expenses for patients due to travel.
Technology	Business Processes / Workflow	Workflows are constrained by current facilities. Each building (or service) operates independently, duplicating many of the processes that happen on the site.	Improvements to operational efficiency- due to the provision of more contemporary facilities and work practices. Streamlining processes to reduce duplication across the site.
	Policies & Procedures	As per NSW Health & MLHD	As per NSW Health & MLHD
	Communication	Technology constraints.	Improvements and access to IT solutions for clinical and non-clinical use (i.e. New Ways of Working).
Technology	Systems	Older systems that can be difficult to use and maintain.	Contemporary systems to improve flow, patient experience and integration with other MLHD sites.
	Equipment	Older equipment that can be unreliable and expensive to maintain.	New equipment to improve efficiencies, improve patient experience, and reduce work health and safety risks
Operation	Operations	Inability to implement contemporary models of care.	New models of care and new ways of working assist to recruit and retain staff. Staff and patient satisfaction increased.
	Performance Measures / KPI's	As per NSW Health directives	As per NSW Health directives
Organisation	Organisational Structure	As MLHD directives	As MLHD directives and creating opportunities.
	Roles & Responsibilities	Roles are centred on providing services within a building or service.	Improved integration across programs, hospital and community services to function as one Tumut team for the benefit of the community

Type of Change	Impact Areas	Current State	Future State
	Skills & Knowledge	Limitation developing new skills due to outdated equipment and lack of training facilities.	New equipment and training facilities will facilitate new learning opportunities for staff.
	Behaviour	Staff may identify themselves with a service or a building.	Staff identify themselves as part of an integrated site- serving the community.

Table 33: Change Definition - Current and Future State

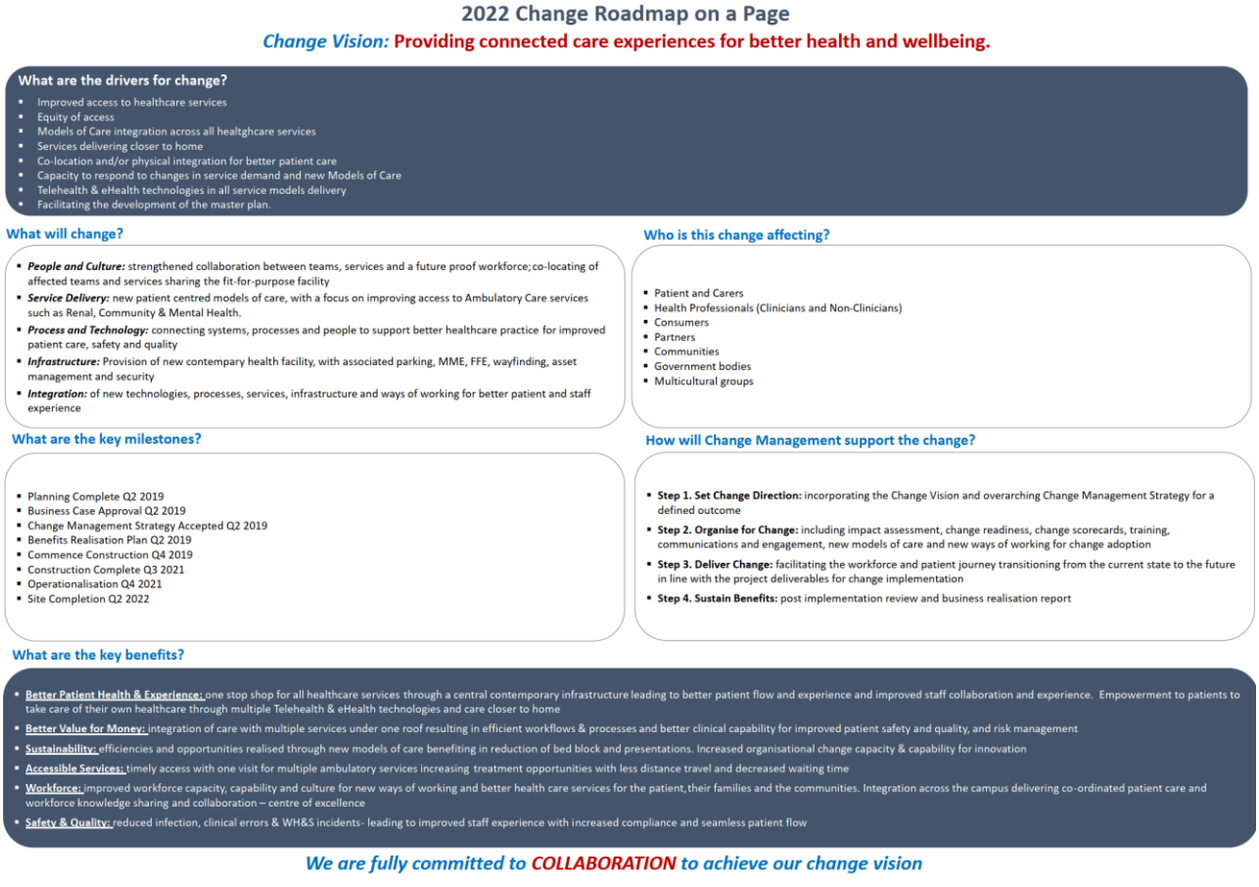


Figure 15: Change Management Roadmap

9 Standard Appendices

Appendix 1 – Clinical Services Plan/ Service Statement
Appendix 2 – Master Plan Report
Appendix 3 – Functional Brief/ Schedule of Accommodation
Appendix 4 – Value Management Report
Appendix 5 – Concept Design Report
Appendix 6 – Cost Plan
Appendix 7 – MLHD Resource Plan
Appendix 8 – Workforce Plan
Appendix 9 – Financial Impact Statement
Appendix 10 – Cost Benefit Analysis
Appendix 11 – Project Governance Arrangements
Appendix 12 – Risk Management Plan
Appendix 13 – Benefits Realisation Plan
Appendix 14 – Change Management Plan
Appendix 15 – Communications and Engagement Plan
Appendix 16 – Aboriginal Health Impact Statement
Appendix 17 – Project Procurement Strategy
Appendix 18 – Master Programme
Appendix 19 – ICT Strategy
Appendix 20 – FFE Plan
Appendix 21 – Gateway Report/s