VALUE MANAGEMENT - A CATALYST FOR CHANGE IN NSW HEALTH PROJECTS?

INTRODUCTION

Since 1988 the NSW Government has endorsed Health as a priority area of Government and has funded a major acceleration of hospital infrastructure reform. The situation back in the 1988 was pretty desperate; the Government had launched an infrastructure reform program, Health 2000, but the Opposition had made significant mileage out of a leaked internal report which claimed the Health system was held together by "Chicken Wire and Chewing Gum". While patently an inadequate description of a system with a total asset value of over $8 billion, this political debate established the clear need to take action to upgrade NSW health facilities.

Expenditure on health infrastructure since the 1950's has rarely exceeded $200m per annum and yet a commercial capital re-investment rate would be between $350 and $400 million. In addition, approximately 45% of our infrastructure is over 40 years old and unsuitable for refurbishment for modern health services.

The condition of NSW infrastructure was however only part of the problem. As in Queensland, the demand on health services was increasing dramatically through population growth, ageing and redistribution. New technologies and treatments were increasing the range of services provided and new policies were set which proposed the people should be treated as close as possible to their place of residence.

All these issues meant that infrastructure reform had to be accelerated in order to provide the standard of health services expected by the Community.

Like Queensland, we in NSW Health had assessed the size of the health infrastructure backlog and the growth need, and had received Cabinet backing for a major works program. Statistics on that program as it now stands are shown below.

NSW Health 10 Year Capital Plan

	Total cost ($b)	Spent to Date ($b)
Authorised Major Works	1.4	0.6
Minor Works (5 yr)	0.1	
Information Technology (5yr)	0.2	0.1
Future Priorities in 10 Year Plan		
- Major Works	1.0	
- Statewide Programs & Minor Works	0.2	
Total Ten Year Plan	2.9	

So where did **Value Management** come in. In this paper I'd like to try to answer two questions.

1) How useful was the Value Management (VM) Process in ensuring effective infrastructure reform?

2) What lessons NSW has learnt after 4 years of effort and over 30 VM Studies?

The NSW Product Evaluation Unit publication nominates **Value Management** as "**A structured system of analysis used to achieve the lowest possible cost consistent with targetted performance parameters, i.e. to maximise value**".

A key thesis of the paper is that the VM process is simply one part of creating an effective end product as required to deliver the nominated health services. Its success or failure as a process must therefore be assessed on how will it assist in achieving that objective. In declaring an early bias, I'd confess my concern is that the VM process tends to solidify team positions rather than engendering an ongoing flexible environment for creative decision making.

An early qualification to be made is that I'm talking from the point of view of a Central Department and hence am principally focussed on the briefing and early conceptual stages of Health projects.

I'll draw from three VM Case Studies:

1)	**Nepean Hospital**	-	Completed in early 1992
	Study Team:		Alan Butler, NSW Product Evaluation Unit, with Roy Barton is Facilitator
2)	**Maitland Hospital**	-	Completed in mid 1992
	Study Team:		Turner Consulting with Brian Farmer as Facilitator
3)	**Inner West Hospital**	-	Completed in early 1993
	Study Team:		PPK Consultants with Gary Richards as Facilitator

Summaries for each of these studies are attached as Appendices.

KEY TRENDS

To assess the VM process as a "catalyst for change" we need to understand the environment that it has been operating in. I've already described the backlog we had to cope with but I'd stress that was only part of the challenge. The real difficulties back in 1988/89 lay in our un-preparedness for the changes which we had to allow for

Current "Key Trends" in health services and facility procurement can be summarised in four areas:-

1) The Evolution from Master to Strategic Planning
2) The development of Integrated Processes
3) Quality and Customer Focus
4) Cost Effective Facility Design

1. Evolution from Master to Strategic Planning

In the seventies and eighties hospital planners around the world reacted to the backlog of inadequate infrastructure and demand growth by master planning hospital campuses. Their objective was to ensure orderly development in line with predicted growth in recurrent funding.

Since 1990, the NSW Government has made it clear that Health has to plan for future service provision within current budget limits. The necessary re-allocation of resources on a population formula has forced many institutions to make difficult choices on the number and types of services offered. This, and the rapid change in patterns of use of hospitals, has meant that Master Plans as little as 3 years old are no longer relevant. It has also forced a strong focus on strategic, or long range planning, combined with maximum flexibility in the facility planning process.

The following table indicates key differences between the previous Master Plan focus and the changed emphasis towards strategic planning.

Master Planning	Strategic Planning
. Expansion oriented	. Shifts focus to the services offered, customer needs and competing providers
. Facility oriented	
. Planning process architect driven with clients providing wish lists	. Organisational restructuring skills more important than technical and/or building skills
. Planning perceived as technical process with focus on buildings and recommended solutions	. Planning integrated into ongoing operational management and change.

Strategic Planning is not just Master Planning with a better "lead in" phase. On the contrary, it embraces a complete change of emphasis with the realisation that planning is service driven and focussed on organisational change as an integral part of ongoing management and reform. The rhetoric changes, "What services do we deliver?" becomes "What services are needed and who will purchase them?". The process also changes with increased focus on restructuring operational practises like admission and discharge policies and the use of extended home care, rather than building new facilities to cater for the extra demand.

Emerging strategic issues for service providers are:

- Competition for patients through location of doctors suites on site, increased customer focus with provision of car parking and streamlined service delivery in modern, "K Mart" type facilities.

- Vertical integration of services with linkage to Ambulatory and GP clinics on site, step down accommodation and extended services into the community.

- Horizontal integration with networked services between hospitals managed by the Area or District administration.

- Community integration into decision making and ongoing operations. This varies from community run hospitals, through to increased involvement in hospital Boards, and community involvement in the planning process.

- The translation of Hospitals into health enterprises (or providers) with payment by DRG (cost of services) and inclusion of asset charges in the cost of service provided.

- Improvements in information and management practises at clinical, nursing and patient levels.

These issues don't mean that new build and/or refurbishment is not necessary but rather that such options can only be considered after detailed strategic planning is completed covering the wider changes in the health environment, potential operational changes and service restructuring. Given the rapid changes in technology and service provision, facility planning then has to be more consultative, flexible and concise rather than the sequential and cumbersome process of Master Planning used in the eighties.

2. Development of Integrated Processes

Reacting to the need for increased operational focus, speed and flexibility in facility planning, **NSW Health has compressed its Process of Facility Planning into five main components**

1. **Services and Asset Management Strategic Planning**
2. **Feasibility Analysis**
3. **Project Definition**
4. **Project Implementation**
5. **Feedback**

These are not separate and sequential steps but rather an integrated whole which has to be managed as such. The management team merges and changes over the process but needs to be seen as an ongoing partnership for eventual success. The tools we use in the process such as Economic Appraisal, Value Management, Risk Analysis and Partnering, likewise need to be seen in the context of the whole rather than each separate phase.

The main message I'd like to deliver in relation to these tools of review is their integration into the process. Two years ago we moved to incorporate Economic Appraisal and VM into the Feasibility study. This integration is now being complemented by the integration of Risk Management and the techniques of Partnering.

Imagine a project where a Services and Asset Strategic Plan has been completed. The next step is to carry out a Feasibility Study, including a Value Review and Economic Appraisal of the Plan and its principle strategies. This feasibility begins the team development which has to occur and is the first time the risk profile of the preferred solution is developed.

From then on, the team "Partnership" widens with progressive testing of the initial concept to ensure objectives are being met. These are not separate reviews or analysis but part of an ongoing team building and risk management process to a common goal.

While this concept is not world shattering, I believe the integrated team approach will create significant benefits. As a simple test, ask how many your project planning team are following the Partnering practise of regularly monitoring their success through the early Project Definition phase. We make it a practise in NSW to insist on the provision of project reports to the monthly Planning and Development Committee meetings. These meetings are the logical time also to regularly monitor the project teams success in pulling together to achieve nominated goals.

The question is how well does the VM process assisted in developing the team environment. As a process it is excellent at achieving a common consensus amongst project stakeholders but I suspect is that this consensus has not often been carried forward in an ongoing way through the life of the project.

3. Quality and Customer Focus

At a recent Customer Focus conference in Sydney the keynote speaker described key trends and issues relating to change. They are relevant to the NSW Government's drive towards customer responsiveness and are another means to evaluate success of the VM process as a Catalyst for Change.

Key Attitude Shifts

From	To
. Mass production	. Customerisation
. Simple process	. Complex process
. Long delivery cycle	. Time is Money
. Loyal Employees	. Empowered Employees
. Functional hierarchies	. Network organisation
. Quality Cost More	. Quality cost less
. Labor/Management conflict	. Collaboration
. Technology driven	. Customer Driven

Change Process

All factors need to be working for effective change.

Pressure for Change + Shared Vision + Capacity for change + Actionable 1st steps = Change

or in NSW Process of Facility Planning terminology.

Strategic Plan +VM +Feasibility +Project Def'n= Project Implementation

To Delight Customers (4 principles)

. Keep your promises
. Keep them informed
. Do it right first time
. Stay with them over time

To achieve customer satisfaction we need to realise that we are in a different era where the customer matters, we need to understand the change process and ensure its working to full potential and we need to aim to delight our customers by attention to their needs and wants. **The question again is "Has the VM Process been a Catalyst in successful implementation of this change thinking and the ultimate delight of our customers"**

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4. Cost Effective Facility Design

The position paper on Cost Effective Design and Planning released in mid 1992 identified major cost drivers as:

- lack of State and Regional Strategic Plans
- over user specification in the Process of Planning
- provision for future need in project designs
- lack of standards for equipment budgeting
- HPU's and HBG's as a minimum rather than a maximum requirement
- overspecification of Engineering requirements
- self fulfilling budgets
- excessive requirements set by BCA/BOFC/Earthquake Codes
- in-adequate review of operational policies adopted in design briefs

The paper recommended the deletion and/or reduction of space in key hospital areas, the more flexible use of space and space sharing and the revision of standards in areas such as ward layouts and the provision of ensuites.

NSW Health has endorsed the recommendations of the study and has sought to achieve breakthroughs in the following areas:

- Revised fire code in BCA
- New Health Building Guidelines (HBG's)
- Revised Hospital Planning Units (HPU's)
- New Guidelines on Engineering Services and Equipment
- Benchmarking of budgeting and space standards
- Design and construct procurement with both Private and Public sectors as operators (e.g. Port Macquarie and Albury projects)
- Life cycle analysis within tender bids
- Investigation of cluster and component design approaches to lock in best practise

The challenge is to use the VM process to set up the environment for changes to be effectively introduced into project designs.

CASE STUDY EVALUATION

For a VM to add value it needs to have assisted in achieving more effective service delivery, better asset management and more efficient provision of health services. The following criteria summarise the key trends such that the case studies can be assessed.

Criteria Summary

1) Strategic Planning

   - Consideration of Services Strategic Plan
   - Consideration of Asset Strategic Plan
   - Integration into Public/Private provider network
   - Integration of vertical services network
   - Consideration of operational change

2) Process Integration

   - VM/Economic Appraisal/Risk Management
   - Ongoing Partnering development
   - Flexibility to ongoing change

3) Quality and Customer Focus

   - Community consultation
   - Consideration of customer issues

4) Cost Effective Design Impact

   - Design improvements and savings
   - Ongoing flexibility in Design and Procurement

Case Study 1 - Nepean Hospital VM

Although the study objectives included a review of the outcomes from the earlier concept study, this review basically focussed on the scheme design. The Executive Summary states "the aim of the VMS was to examine the Design Proposal to ensure effectiveness, appropriateness and client needs and objectives are achieved in the most effective manner"

Comments against the above criteria are as follows:-

- **Strategic Planning and/or Operational Change:** Superficial examination only (reflecting the largely technical make up of the VM team) and did not get beyond comment about theatre utilisation. Further, the study did not assess the potential benefits of networking between public and private hospitals despite the considerable opportunity in this area as evidenced by the later development of a co-located private hospital/clinic concept.

- **Process Integration:** As above, the VM did not relate back to the earlier concept study and its focus on project issues did not expand to ongoing assessment of risk or the development of partnering. An effort was made by the Study Director to achieve ongoing monitoring of the action plan but despite an early flurry of letters this was not followed through.

- **Quality and Customer Focus:** Not considered and remained issues for the planners on the project and later development by the hospital management.

- **Cost Effectiveness Design:** Significant design improvements were achieved and savings of $8m in a budget of around $34m were claimed. The study endorsed the adoption of Design Document and Construct as the preferred procurement system and yet it is in this area where I as client am most critical. Having completed the VM the team proceeded to "lock-in" and over-document the preferred solution to the extent that the DD&C tender process was compromised. Each of the DD&C tenders had further refinements capable of achieving recurrent efficiencies and capital savings, but these were frozen out by advanced state of the documentation of the conforming tender design.

The question is, was the VM process inadequate in not setting up an ongoing mentality of openness to change and risk evaluation. Certainly twenty one people contentiously worked to better the design over two days, and an excellent hospital has been achieved. My concern is that this VM was very much a review at a point in time and did not develop the flexibility and ongoing team relationship to its full potential.

Case Study 2 - Maitland Hospital

The Maitland VM objective was to "Determine the most cost effective means of delivering required acute hospital services to the residents of Maitland, Lower Hunter and Western areas of Newcastle in capital and recurrent terms". Specific examination was required to strategic services planning, the review of current assets including life cycle costing, the assessment of options and funding alternatives.

Evaluation against the four criteria indicates as follows:-

1. **Strategic Planning**: We were successful in appropriately addressing public service needs and the strategies for the provision of public services but relatively unsuccessful in broadening views on the integration of private services and the potential impacts and/or opportunities in operational change. This is not to say these issues were not addressed, we engaged a specialist consultant to review and advocate for the needs of the private hospital industry at the VM and then later moved to instigate an operational review of the current hospital to set up the climate for change as the new facility is constructed. The main problem was that the public health lobby was just too strong in the VM process and the initial review was too broad to adequately address operational change. Finally, no attention was given to involvement of the Community in the review process.

2. **Process Integration**: This VM was one of the first where options were agreed and then an action plan determined to ensure all data was prepared for the subsequent economic appraisal. In this case, subsequent review of the design development was then done through independent review and benchmarking by peer designers, not a second VM review. One of the good factors was that the project team spirit developed at the VM remained intact through this subsequent design review process. On the negative side I am afraid this team also tended to lock in on the preferred solution and also appears to have over documented the DD&C tender.

3. **Quality and Customer Focus:** Not considered in the VM and included into the project through the planning process.

4. **Cost Effective Design Input:** Not considered in the VM but later included through independent design review and cost benchmarking with similar NSW and other Australian projects. Savings were created but further efficiencies are expected through the DD&C tender process (tenders close shortly).

In summary, the Maitland study fulfilled most of its objectives and set up an environment for ongoing evaluation and refinement. Its failures could however be said to be:

- the consideration of private health services failed to broaden views held (to the extent that the co-location of private facilities was later rejected).

- we had not developed any process for involvement of the community and/or customer focus in the decision making process.

- the team formed a defensive position on its design (albeit less so in this case) and proceeded to lock it in rather than maintaining flexibility and openness to change through the procurement system adopted.

Case Study 3 - Inner West Hospital

The integration of Concord Repatriation Hospital into the NSW system gave NSW health the opportunity to carry out significant reforms generating long term recurrent savings. The amalgamation of two inner city hospitals into the new Inner West hospital was a key element of that reform package. Operating costs of approximately $18m per annum were saved and two substandard facilities are being replaced by a modern, customer focussed, new hospital.

In late 1992 a Strategic Services Plan had been completed and the Department moved to investigate related Asset Strategies. Considerable controversy was expected with five Local Government and three Health Areas involved. The Procurement Feasibility process was used to investigate the issues in parallel to a Community Consultation Program consisting of a Community based Steering Committee and local meetings.

The VM study was a crucial part of the Procurement Feasibility Study. Detailed asset and services information was prepared for the teams consideration and qualitative analysis used to address issues of concern to the consultative process. These included such issues as community needs, services continuity during construction, access and functionality.

Comments against my criteria are as follows:-

1. **Strategic Planning and Operational Change:** One of the biggest problems we faced was the parochial support of the respective communities in support of their hospitals despite the benefits that a new facility could offer. Published information and Departmental advocacy of the strategic planning had little effect as central planners basically lack of credibility in the public eye. The advantage of the VM and Feasibility Study was that this issue was addressed in a consultative way which was able to demonstrate that the options were fairly evaluated by the consultant team. Given the complexity of the issues, this was a considerable achievement.

2. **Integrated Processes:** This study has been one of our most effective examples of integrating the VM and Economic Appraisal techniques into the Procurement Feasibility Study and then linking the results of that process into a community review. Nevertheless, personnel changes in the responsible Area Health Service has meant that continuity has been lost and the team building carried out in the VM has not been carried forward.

3. **Quality and Customer Focus:** User satisfaction was key to the success of this rationalisation and hence key to the targetted recurrent savings program. The question was how to convince the community that one quality service was better than two substandard, though more local facilities. The principle benefit of the value review process as finally presented in the Feasibility Report was that it enabled this issue to be addressed against all options and the economic benefit results. In a real sense the processes used enabled the VM to develop a "shared vision" and for this to be broadly communicated.

4. **Cost Effective Design:** Although carried out at strategic level the VM focussed on site and design issues and produced comparative budgets, both capital and recurrent. These were preliminary only however and further design review is to be instigated shortly now that the site options are being developed.

VM purists may be critical of this study and yet in terms of client benefits and the criteria established in this paper, it measures up very well. It enabled very difficult issues to be successfully addressed and developed all the key facets for successful change.

LESSONS LEARNT IN NSW

Value Management has become established in NSW Health as a viable means of reviewing difficult projects and establishing consensus on actions required to achieve project efficiency. It is interesting to note that despite over 30 reviews being carried out, many on very sensitive issues, we have not had anyone go outside the confidentiality of the process. Stakeholders clearly like to be consulted and respect the process for what it is.

The biggest concern I have is that VM's take a lot of resources and have a tendency to become talk-fests. In particular, the provision of information can be laborious and the structure of the review can be overtaken. For that reason, I'd suggest **VM practitioners need to more clearly establish the proposed methodology of the particular review at its outset and ensure this meets the respective client objectives.**

Secondly, I believe VM practitioners shouldn't get precious about their process. We have had cases where reviews have been claimed "Not to be a VM". My response is so what? I simply need a process to achieve certain objectives and the VM approach fits the bill.

Lastly I'd emphasise that success depends on a number of key factors.

- **Clear corporate and services strategic planning** to be in place and able to be discussed. This includes corporate goals, statewide service strategies and resource implications, as well as long term definition of capital funding and operational change issues.

- **Integration of the VM review** into the wider Process of Facility Planning with clear and ongoing involvement of the respective team members. Our emphasis in NSW Health is to ensure Project Definition and Implementation is completed expeditiously and to hold detailed planning until funds for these stages is available. The feasibility therefore is a key stage in the process and successful completion of a combined VM/Economic Appraisal is recognised as the major decision point on health projects.

- **Forward preparation** on both information and VM methodology needs to be thorough and well targetted. In particular, the VM facilitator needs to consult in detail with the key stakeholders before the VM review day to define what objectives are held and to outline the process and techniques proposed.

Finally, I'd stress that the 'left field' change issues are the hardest to address but are those likely to make the results of a review superfluous in key areas. Operational Change, Public/Private mix and Customer Focus thinking are the specific areas of most concern in NSW Health.

CONCLUSION

Does the VM process create more effective Service Delivery and Asset Management? In NSW our experience has been that it does but it is simply one element of the ongoing decision making process and flexibility to react to change is the key element to success.

SUMMARY TABLE - CASE STUDY DATA

	NEPEAN	MAITLAND	INNERWEST
Project Status	Scheme design in development	Conceptual design prepared	Services strategy developed
Objective	To review design to ensure cost effectiveness	To review service and asset strategies and evaluate options	To review service and asset strategies and evaluate options
Duration	2 day study	1 day as part of PFS	1 day as part of PFS integrated with community consultation
Independents	- costings - planning - buildability - Eng. Services	- Total Asset Management - private hospitals	- serv. planning - facility planning - traffic - costings - condition surveys
Process	- Introduction - Objectives - Information - Analysis and ideas generation - Option evaluation - Action Plan	- Introduction - Objectives - Information - Ideas generation - Option analysis and ranking - Action Plan	- Introduction - Objectives - Information re costs (cap & recurrent) - Kepner Tregoe Option analysis - Action Plan

SUMMARY TABLE - CRITERIA EVALUATION

Criteria	NEPEAN	MAITLAND	INNERWEST
1. Strategic Planning	Superficial examination only	Well covered in both Services and Asset Strategic Planning. Consideration of public/private integration lacked depth.	Evaluated services and asset strategic planning in consultative way. Public/private integration not addressed.
2. Process Integration	Not integrated	VM/EA integrated. Later design reviews and operational reviews helped by the team environment created.	VM/EA integrated in PFS. PFS integrated into community consultation.
3. Quality and Customer Focus	Not considered	Not considered	Handled through links to community consultation.
4. Cost Effective Design	Significant achievements claimed but not borne out by later DD&C competition	Considered in later design reviews and cost benchmarking but concerns held over design flexibility regards operational practise	Investigated options but not able to address design solutions.
Conclusions	Study team was limited by its technical bias and focus. The subsequent process was not sufficiently flexible to allow inclusion of potential further refinements	Successful study other than public/ private mix and customer/communit y involvement. Concerns held that the study also fixed defensive positions which inhibited later refinement.	Strategic Study - successful in option evaluation and community consultation.

NEPEAN HOSPITAL (Stage One $80m in June 90 $'s)

Date of VM:	Early 1992 (previous concept VM carried out in mid 1990)
Duration:	2 Days
Study Team:	Alan Butler Value Manager Roy Barton, Facilitator 21 people in attendance
Project Status:	Scheme design on Stage One around 50% completed.
VM Objective:	To review developing design and to ensure effectiveness appropriateness and client needs/objectives are achieved in the most cost effective manner.
Independent Team Members:	Covering: - Cost Management - Facility Planning - Buildability - Programming - Engineering services

Particular Issues

- Review of mid 1990 concept VM outcomes and strategies
- Effectiveness of operational funding increases and impact of current management practises on infrastructure requirements
- Priority for Stage 1 works to be given to facilities which maximise service outputs (e.g. day surgery)
- Design, Engineering services and building policy issues resolution (principally Engineering Services, Service Standards, BCA implementation)
- Private sector participation

VM Process

- Introduction and Objectives
- Provision of Information (Corporate/Area/Hospital)
- Project Analysis (ideas generation on Engineering services, planning, building form, management, project delivery and acceleration of services delivery)
- Option Evaluation
- Action Plan

Impacts of VM Process

- Scheme Design improved through peer review with potential savings of $8-9m (i.e. 10%) subject to corporate and team will.
- Agreement to proceed via DD&C procurement process
- Key issues identified and review process instigated into potential savings.

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MAITLAND HOSPITAL

Date of VM:	May 1992
Duration:	1 Day
Study Team:	Turner Consulting, Value Manager Brian Farmer, Facilitator 20 people in attendance
Project Status:	Concept only, previous scheme had been obeyance pending funding approval
VM Objective:	Review of service and asset strategic plan for Lower Hunter Health Services, with economic appraisal of alternative options
Independents:	Covering: - Government Asset Management planning - Private sector needs and opportunities

Particular Issues

- Three hospitals in close proximity service the lower hunter. Early studies indicated it may be possible to replace all three with one facility designed to maximise service efficiency and consumer satisfaction.
- The Cabinet Capital Works Committee had previously requested the Department to investigate private sector participation before proceeding with the Maitland project.
- The Lower Hunter strategic review had confirmed the referral role of Maitland Hospital but indicated that any additional recurrent funds would have to be drawn from the internal redistribution.

VM Process

- Introduction and Objectives
- Provision of Information (services & asset strategies, Total Asset Management guidelines, asset conditions and maintenance, recurrent costs and funding constraints)
- Ideas generation
- Current Issues (Development options and costs, Life Cycle costs, Private Sector participation)
- Options analysis and ranking
- Action Plan

Impacts of VM Process

- Agreement reached on options and criteria for economic analysis
- Key issues identified and participants allocated data inputs as required to complete analysis
- Private hospital demand and impact considered in parallel to public planning process.

INNER WEST HOSPITAL, SYDNEY

Date of VM: Early 1993

Duration: 1 Day

Study Team: PPK Consultants
Gary Richards, Facilitator
22 people in attendance

Project Status: Services strategy completed. Recommended replacement of two existing hospitals as part of overall rationalisation linked with the integration of Concord Repatriation Hospital into the NSW State network.

VM Objective: Review of options available to relocate new hospital as integrated part of a "Procurement Feasibility Study".

Independents: Covering:
- Not for profit health sector
- Traffic analysis
- Health services planning
- Hospital facility planning
- Quantity surveyors
- Condition surveys and demolition

Particular Issues

- Preparatory works for the VM review included
  - condition surveys of the existing hospitals
  - research on alternative site options
  - analysis of demand and supply network (public and private)
  - local access and parking analysis of alternative sites
  - development of capital and recurrent costs of each option.

- The services strategy crossed two Health Area boundaries and Five Local Government Areas

- A parallel community consultation process had been established by the Minister to recommend the most appropriate development strategy. This group consisted of local politicians, residents, hospital staff, clinicians and independent facilitator. The progress of the Procurement Feasibility Study as provided as input to the Community Consultative Group.

VM Process

- Introduction and Objectives

- Provision of preparatory research and option statistics

- Kepner Tregoe review of options with focus on
  - site suitability for hospital facility
  - capacity to meet community needs
  - provision of health services during construction
  - local access and parking
  - functionality of service provision
  - impact on human resources

- Action Plan

Impacts of VM Process

- Agreement reached on ranking of options from cost efficiency and qualitative measures

- Key issues identified and presented for consideration by Community consultative committee.