CAB-25-MIN-0309

Cabinet

Minute of Decision

Report of the Cabinet Social Outcomes Committee: Period Ended 12 September 2025

On 15 September 2025, Cabinet made the following decisions on the work of the Cabinet Social Outcomes Committee for the period ended 12 September 2025:

s9(2)(f)(iv) [redacted]

SOU-25-MIN-0118	**Approval of the New Dunedin Hospital Inpatient Building Project Implementation Business Case** Portfolio: Health	CONFIRMED

Rachel Hayward
Secretary of the Cabinet

SOU-25-MIN-0118

Cabinet Social Outcomes Committee

Minute of Decision

Approval of the New Dunedin Hospital Inpatient Building Project Implementation Business Case

Portfolio **Health**

On 10 September 2025, the Cabinet Social Outcomes Committee:

Background

1 **noted** that the previous government:

1.1 approved the previous investment planning stage Detailed Business Case in April 2021, for the New Dunedin Hospital (NDH), with a budget of $1,470.000 million [CAB-21-MIN-0124];

1.2 in December 2022, approved $110.000 million of additional funding due to a design reset resulting in reduced capacity;

1.3 in April 2023, approved the allocation of an additional $10.000 million to close out final clinical risks associated with the design reset;

2 **noted** that in March 2024, Cabinet approved the establishment of the "New Dunedin Hospital" tagged capital contingency as set out below to meet the cost pressures funding requirement faced by NDH, with drawdown subject to Cabinet approval of an Implementation Business Case:

	$ millions – increase / (decrease)				
	2023/24	**2024/25**	**2025/26**	**2026/27**	**2027/28 & outyears**
New Dunedin Hospital – tagged capital contingency	-	290.000	-	-	-

[CAB-24-MIN-0095]

3 **noted** the recent appointment of a Crown Manager to the NDH Inpatient Building project, who is responsible for the delivery of the Implementation Business Case by 11 September 2025 and negotiation of the final contract of the main works package of the Inpatient Building project;

4 **noted** that the Implementation Business Case for the NDH Inpatient Building project has been completed in accordance with the Better Business Case framework;

Implementation Business Case

5 **approved** the Implementation Business Case for the NDH Inpatient Building, attached as Appendix One to the paper under SOU-25-SUB-0118;

6 **noted** the following changes to the previously approved Detailed Business Case:

6.1 the proposed scope for the NDH Inpatient Building project will provide reduced capacity when operational and allows for expansion subject to further investment and approvals;

6.2 the project will reach practical completion in October 2030 and the Inpatient Building will be operational in February 2031;

6.3 the procurement approach has changed from a Fixed Price Lump Sum model to the Collaborative Delivery Agreement model;

6.4 s9(2)(b)(ii), s9(2)(f)(iv)
:

s9(2)(b)(ii), s9(2)(f)(iv)

7 s9(2)(b)(ii)

Contingency drawdown

8 **agreed** that the further work described in paragraph 2 above has been satisfactorily completed and the $290.000 million from the "New Dunedin Hospital" tagged capital contingency can be drawn down;

9 **approved** the following changes to appropriations to provide for the decision in paragraph 8 above, with a corresponding impact on net core Crown debt:

Vote Health **Minister of Health**	**$ millions – increase / (decrease)**				
	2025/26	**2026/27**	**2027/28**	**2028/29**	**2029/30 & outyears**
Non-departmental Capital Expenditure: New Dunedin Hospital 2021-2026 MYA	290.000	-	-	-	-
Total Capital	**290.000**	**-**	**-**	**-**	**-**

10 **agreed** that the changes to appropriations for 2025/26 above be included in the 2025/26 Supplementary Estimates and that, in the interim, the increase be met from Imprest Supply;

11 **agreed** that capital expenditure incurred under paragraph 9 above be charged against the New Dunedin Hospital tagged capital contingency described in paragraph 2 above;

12 **noted** that, following the adjustment detailed in paragraph 11 above, the tagged capital contingency is now exhausted and therefore closed;

s9(2)(b)(ii)

Next steps

17 **directed** the Crown Manager to enter a commercial contract with CPB Contractors Pty Limited for the main works package of the NDH Inpatient Building project;

18 **authorised** the Minister of Health and Minister of Finance jointly to:

18.1 take decisions on any Health New Zealand funded budget increase or any material scope changes to the NDH programme;

18.2 approve any minor changes required to progress procurement or construction activities.

Jenny Vickers
Committee Secretary

Present:
Rt Hon Winston Peters
Hon Chris Bishop
Hon Simeon Brown (Chair)
Hon Dr Shane Reti
Hon Mark Mitchell
Hon Tama Potaka
Hon Nicole McKee
Hon Casey Costello
Hon Penny Simmonds
Hon Karen Chhour
Hon Nicola Grigg
Hon Scott Simpson

Officials present from:
Officials Committee for SOU

Budget Sensitive

Office of the Minister of Health

Cabinet Expenditure and Regulatory Review Committee

Approval of the New Dunedin Hospital Inpatient Building Project Implementation Business Case

Proposal

1 I seek Cabinet's:

1.1 approval of the New Dunedin Hospital (NDH) Inpatient Building project Implementation Business Case (ImBC), s9(2)(b)(ii)

1.2 agreement to drawdown the $290.000 million tagged capital contingency established in March 2024 subject to Cabinet's approval of the ImBC referred above; and

1.3 s9(2)(b)(ii)

2 I ask that Cabinet delegates approval to me, and the Minister of Finance for any Health New Zealand (Health NZ) funded budget increase or any material scope changes to the NDH programme.

Relation to government priorities

3 The NDH programme is a large and complex vertical health infrastructure programme that supports three of the five Government's health targets: shorter stays in emergency departments, shorter wait times for treatment and shorter wait times for first specialist assessment.

4 Investment in NDH will enhance economic development opportunities, supporting the Government's priorities for thriving and sustainable regions. At its peak, construction of NDH will add around $100 million annual GDP to the local economy, an increase of 1.6 percent. It will also be supporting 914 full time equivalent jobs. Over the 10-year construction period, the accumulated impact is $429 million additional GDP.

Executive summary

5 The NDH programme comprises an Inpatient Building, an Outpatient Building and enabling and site works. This paper seeks Cabinet's approval of the ImBC for the NDH Inpatient Building project. Approving the ImBC will allow the project to progress to the delivery phase.

6 s9(2)(b)(ii)

7 The ImBC also confirms:

7.1 the finalised scope that reflects recent refinements to manage cost;

7.2 a revised delivery schedule, with the Inpatient Building project expected to be operational in February 2031;

7.3 a total capital investment of s 9(2)(b)(ii) required for the Inpatient Building project only, of which this paper seeks:

s9(2)(b)(ii)

7.4 adoption of a collaborative delivery mode, which shares risk between the contractor and the Crown, and incentivises cost efficiency through joint governance and transparent decision-making processes.

8 The success of the Inpatient Building project is dependent on several key workstreams, including workforce planning, digital transformation and models of care.

Background

9 The NDH programme is currently the largest health infrastructure project in New Zealand and will replace the current Clinical Service Building and Ward Block Dunedin Hospital, which is at the end of its economic and serviceable life.

10 The Detailed Business Case (DBC) for the NDH programme was approved by Cabinet in April 2021 with a budget of $1,470.000 million [CAB-21-MIN-0124]. Since approval, the programme has experienced consistent challenges which have resulted in delays, additional costs, and changes to scope and design. The programme now has a total budget of $1,880.000 million (see Table 1).

Table 1: Previous cost increases for the NDH programme ($million)

Date	Description	Additional funding	Tagged Contingency	NDH Total
Apr 2021	Cabinet approved DBC for the NDH programme.			$1,470.000
Dec 2022	Cost pressures and design reset of Inpatient Building.	$110.000		$1,580.000
Apr 2023	Resolution of clinical risks from the design reset.	$10.000		$1,590.000
Mar 2024	Planning and design issues, and further cost escalation, resulting in establishment of a tagged contingency.		$290.000	$1,880.000

11 As part of the March 2024 decision, Cabinet was advised of additional assurance activities for the NDH programme, including a one-off independent review. This review highlighted the approved budget was unlikely to be sufficient to cover the project scope. This was later confirmed by the Quantity Surveyor estimate and the contractor's tender submission.

12 In September 2024, the previous Minister of Health directed Health NZ to develop options to deliver the NDH programme within the existing appropriation of $1,880 million.

13 In December 2024, Ministers noted Health NZs intent to progress with the preferred option, Option One, which has reduced capacity upon opening. s9(2)(b)(ii)

14 In June 2025, I appointed a Crown Manager to the NDH Inpatient Building project, given the scale and complexity of the Inpatient Building project and the risk this posed to Health NZ.

15 The Inpatient Building project has been apportioned s 9(2)(b)(ii) of the total $1.880.000 million budget, including the tagged contingency of $290.000 million. The release of the tagged contingency is subject to Cabinet's approval of this ImBC [CAB-24-MIN-0095].

Analysis

16 I am seeking your approval of the ImBC for the NDH Inpatient Building so that the Crown Manager can enter a commercial contract with CPB Contractors Pty Limited (CPB) for the main works package of the NDH Inpatient Building project. The ImBC, attached as Appendix 1, outlines changes to scope (in line with Ministers previous advice to Health NZ), s9(2)(b)(ii)

Project scope and timelines

17 The ImBC reconfirms the need for investment due to the poor condition of the existing clinical facilities, which erode quality of care, restrict service capacity and are unable to adapt to innovative models of care. The project scope has evolved since the DBC was approved to better align with the approved budget while maintaining alignment with the expected benefits.

18 The preferred option, Option One, reduces the initial number of beds, operating theatres and imaging modalities the Inpatient building will have when opened, shown in Table 2.

Table 2: NDH Programme Bed Capacity Overview

	Existing hospital capacity	Current approved scope (2022)	Preferred Option (Option One)	Modelling (2037/38)	Capacity with future investment
Overnight Beds	396 329 are resourced[1]	410 (incl. 10 cold shell[2] and 12 beds future proofed)	351 (+43 beds cold shell, 10 ICU as interim workspace)	387	404
Operating/ Interventional Theatres	17 (+1 leased)	23 (+3 cold shell)	22 (+1 Hybrid & 1 Operating Theatre shell)	21	24
Same Day & Ambulatory Rooms	36	44	41	18	44
ED spaces	42	53	53	53	53
Imaging modalities[3]	17	24 (+2 shell)	20 (+6 shell)	22	26

[1] A hospital bed that is physically available and actively staffed with clinical personnel, equipment, and infrastructure to deliver patient care.
[2] A shell of the building without any services (e.g. electrical, water, sewer).
[3] MRI, CT, Ultrasound, Fluoroscopy, general x-ray, etc.

19 This option was assessed as best placed to realise the benefits of investment objectives and provided an additional futureproofed floor to meet future demand.

20 Health NZ has assured me that sufficient capacity will be available to meet expected demand upon opening, supported by changes to models of care that will enable more services to be delivered in the community and improve access through digital health solutions.

21 The facility has also been designed to allow for future expansion, which will be necessary to align with forecast demand modelling and ensure the hospital meets population needs over time. This approach balances immediate fiscal constraints with the need for long term service sustainability.

22 Option One was developed in collaboration with and endorsed by the Clinical Transformation Group. It was endorsed by Southern's senior clinical and operational leaders in December 2024. The ImBC, including the scope, has been endorsed by the National Clinical Chief Health Service Delivery Planning of Health NZ.

23 The DBC projected the Inpatient Building would be operational in April 2028. The project is now forecast to reach practical completion in October 2030 and to be operational in February 2031(see Appendix 3 for detailed timelines). This delay is due to the multiple design resets, s9(2)(ba)(i)

Financial Implications

24 As noted previously, following the formal separation of the Outpatient and Inpatient Projects, the budget for the Inpatient Building project is s 9(2)(b)(ii) including the $290.000 million tagged contingency established in March 2024.

25 s9(2)(b)(ii)

s9(2)(b)(ii)

26 s9(2)(b)(ii)

27 I have outlined my expectations of active risk management to ensure the project contingency remains adequate as risks evolve, and that any risk to cost or schedule are identified and mitigated early to preserve delivery confidence.

28 s9(2)(b)(ii)

29 s9(2)(f)(iv)

Implementation

30 In October 2021, CPB was selected as the preferred supplier to undertake an Early Contractor Engagement (ECE) phase for the Inpatient Building, providing buildability advice on the building design. The DBC anticipated the ECE phase would be followed by a Fixed-Price Lump Sum contract. s9(2)(ba)(i)

31 In March 2024, following due diligence into CPB's performance on other public sector contracts, Health NZ reiterated its confidence in proceeding with CPB [CAB-24-MIN-005].

32 I commissioned an independent rapid review to confirm the feasibility of continuing with CPB and identify options to mitigate risks. The review, noting the requirement to urgently progress the Inpatient Building, confirmed the feasibility of continuing with CPB under the Collaborative Delivery Agreement model.

33 The Collaborative Delivery Agreement model brings forward the required timing for contract signature to allow the contractor to start ordering long lead items. s9(2)(b)(ii)

Collaborative Delivery Agreement Model

34 Under this model, a fixed price lump sum portion of the contract is agreed to, and the remaining balance is then delivered in a transparent manner with risk/reward shared between the parties, further explained in Appendix 4.

35 s 9(2)(b)(ii) [redacted]

s 9(2)(b)(ii) [redacted]

36 s9(2)(b)(ii)

37 I am seeking your agreement for the Inpatient Building project to proceed using a Collaborative Delivery Agreement model.

Management Case

38 In June 2025, I appointed Evan Davies as Crown Manager to the Inpatient Building project. He is supported by a Project Director and will be supported by a Project Board following its establishment. As Crown Manager, he is responsible for governing the delivery of the programme, including management of time and budget, quality, risks and performance.

39 The Southern Engagement Group has been established to strengthen engagement with key stakeholders. Membership is currently being confirmed in consultation with Dunedin City's Mayor, and will include Dunedin City Council, the former Southern District Health Board, Otago Regional Council, University of Otago and Waka Kotahi.

40 The benefits realisation plan was updated in June 2025 and is being led by the Health NZs Southern Operational Readiness Team (SORT). The SORT will reinstate regular reporting on benefits realisation from 2026 and will recommend management actions necessary to ensure benefits are realised.

Investment Assurance

41 As per Cabinet Office circular CO (23) 9 requirements, a Gateway Review is mandatory before Cabinet consideration of an ImBC. s9(2)(f)(iv)

42 The Targeted Investment Review provided a delivery confidence assessment of amber. The review found successful delivery of the project appears feasible, provided appropriate governance arrangements, skilled contract management, links to the broader NDH Programme, and effective and proactive communications are put in place promptly.

43 The Crown Manager agrees with all seven recommendations (see Appendix 2) and is in the process of establishing a Project Board.

44 The Review recommended a further Targeted Investment Review is completed in the next 12 months to focus on commercial arrangements and project governance and management.

Next Steps

45 Pending your direction, the Crown Manager will finalise and enter the contract with CPB for the construction of NDH Inpatient Building.

46 s9(2)(f)(iv)

47

Cost-of-living Implications.

48 There are no cost-of-living implications.

Legislative Implications

49 There are no legislative implications.

Impact Analysis

50 There are no regulatory proposals in this paper and a Regulatory Impact Statement is not required. A Climate Implications of Policy Assessment is not required.

Population Implications

51 NDH requires significant investment to address deteriorating facilities that currently restrict service capacity and adoption of more efficient and effective models of care. This investment in the inpatient building for NDH contributes to the development of a

stronger public health system equipped to deliver better health outcomes for the population of Otago and Southern region.

Human Rights

52 There are no human rights implications arising from the proposal in this paper.

Use of external Resources

53 While no external resources were used in the development of this paper, the development of the ImBC used information from engaged consultants such as Quantity Surveyors, programmers, and financial and economic advisors.

Consultation

54 The following departments, agencies and entities have been consulted; The Treasury, Health NZ | Te Whatu Ora, New Zealand Infrastructure Commission | Te Waihanga and the Department of the Prime Minister and Cabinet.

Communications

55 My office will prepare communications to support an announcement in consultation with the Minister of Finance if Cabinet approves the recommendations.

Proactive Release

56 I propose the proactive release of this paper and the ImBC within 30 business days from the day the final decisions are taken to Cabinet. Any redactions will be made in accordance with the Official Information Act 1982.

Recommendations

The Minister for Health recommends that the Committee:

1 **Note** the previous government:

1.1 **approved** the previous investment planning stage Detailed Business Case in April 2021, for the New Dunedin Hospital (NDH), with a budget of $1,470.000 million [CAB-21-MIN-0124];

1.2 in December 2022, **approved** $110.000 million of additional funding due to a design reset resulting in reduced capacity;

1.3 in April 2023, **approved** the allocation of an additional $10.000 million to close out final clinical risks associated with the design reset;

2 **Note** in March 2024, Cabinet [CAB-24-MIN-0095] **approved** the establishment of the New Dunedin Hospital – tagged capital contingency to meet the cost pressures funding requirement faced by NDH, with drawdown subject to Cabinet approval of an Implementation Business Case.

	$ millions – increase / (decrease)				
	2023/24	**2024/25**	**2025/26**	**2026/27**	**2027/28 & outyears**
New Dunedin Hospital – tagged capital contingency	-	290.000	-	-	-

3 **Note** the recent appointment of a Crown Manager to the NDH Inpatient Building project, who is responsible for the delivery of the Implementation Business Case by 11 September 2025 and negotiation of the final contract of the main works package of the Inpatient Building project.

4 **Note** that the Implementation Business Case for the NDH Inpatient Building project has been completed in accordance with the Better Business Case framework.

5 **Approve** the Implementation Business Case for the NDH Inpatient Building.

6 **Note** the following changes to the previously approved Detailed Business Case:

6.1 the proposed scope for the NDH Inpatient Building project will provide reduced capacity when operational and allows for expansion subject to further investment and approvals;

6.2 the project will reach practical completion in October 2030 and the Inpatient Building will be operational in February 2031;

6.3 the procurement approach has changed from a Fixed Price Lump Sum model to the Collaborative Delivery Agreement model;

6.4 s9(2)(b)(ii)

Contingency drawdown

8 **Agree** that the further work described in recommendation 2 above has been satisfactorily completed and the $290.000 million from the New Dunedin Hospital – tagged capital contingency can be drawn down.

9 **Approve** the following changes to appropriations to provide for the decision in recommendation 10 above, with a corresponding impact on net core Crown debt:

Vote Health **Minister of Health**	$ millions – increase / (decrease)				
	2025/26	2026/27	2027/28	2028/29	2029/30 & outyears
Non-departmental Capital Expenditure: New Dunedin Hospital 2021-2026 MYA	290.000	-	-	-	-
Total Capital	**290.000**	**-**	**-**	**-**	**-**

10 **Agree** that the proposed changes to appropriations for 2025/26 above be included in the 2025/26 Supplementary Estimates and that, in the interim, the increase be met from Imprest Supply.

11 **Agree** that capital expenditure incurred under recommendation 9 above be charged against the New Dunedin Hospital tagged capital contingency described in recommendation 2 above.

12 s9(2)(f)(iv)

s9(2)(b)(ii)

Next Steps

17 **Direct** the Crown Manager to enter a commercial contract with CPB for the main works package of the NDH Inpatient Building project.

18 **Authorise** delegated authority to me, and the Minister of Finance for any Health New Zealand funded budget increase or any material scope changes to the NDH programme.

19 **Authorise** delegated authority be given to the Ministers of Health and Finance to approve any minor changes required to progress procurement or construction activities.

Hon Simeon Brown

Minister for Health

Health New Zealand
Te Whatu Ora

Implementation Business Case – New Dunedin Hospital Inpatient Building

Prepared by: Wayne Stevens

Date: 1 August 2025

Version: 3.1

Status: Endorsed

Document control

Document information

File Name	Implementation Business Case – New Dunedin Hospital Inpatient Building
Document Owner	Wayne Stevens Kieran Reilly
Issue Date	5 August 2025

Document history

Version No	Issue date	Changes
1	June 2025	First revised draft
2	July 2025	Updated for review with MoH and Treasury – except Financial Case
3	1 August 2025	Updated – penultimate version
3.1	4 August 2025	Endorsed by Crown Manager

Document distribution

Role	Name
Head of Infrastructure Planning and Investment Infrastructure and Investment Group (IIG)	Aaron Matthews
Finance Director – Enterprise Capital Investments	Timneen Taljard
Ministry of Health	Jo Strachan Hope Grace Kane
Treasury	Martin Watson
New Zealand Infrastructure Commission	Rebecca Robertshawe
Office of Chief Executive HNZ	Alisha Brash

Business case signoff

Recommended for authorisation by

Role and Name	Signature	Date
Tony Lloyd Inpatient Building Project Director	s9(2)(a)	4 August 2025

Authorised/endorsed by:

Role and Name	Signature	Date
Evan Davies Crown Manager	Refer Annex 1	4 August 2025

Glossary

Term	Definition
%NBS	Percent of New Building Standard
AAU	Acute Assessment Unit
AF8+	Alpine Fault Magnitude 8
AH	Allied Health
ARC	Aged Residential Care
ASB	Acute Services Building
AT&R	Assessment, Treatment and Rehabilitation
AusHFG	Australasian Health Facility Guidelines
BoH	Back of House
Cath Lab	Cardiac Catheterisation Laboratory
CBA	Cost Benefit Analysis
CCCS	Conditions of Contract for Consulting Services
CCU	Coronary Care Unit
CHD	Congenital Heart Disease
CIC	Capital Investment Committee
CIIO	Chief Infrastructure and Investment Officer
COPD	Chronic Obstructive Pulmonary Disease
COVID-19	Coronavirus 2019
CSF	Critical Success Factor(s)
CSP	Clinical Services Plan
D&D	Data & Digital
DBC	Detailed Business Case
DSA	Detailed Seismic Assessment
DSU	Day Surgical Unit
ECE	Early Childhood Education
ECG	Electrocardiogram
Echo	Echocardiography
ECI	Early Contractor Involvement
ED	Emergency Department
ELT	Executive Leadership Team
EMRAM	Electronic Medical Record Adoption Model

Term	Definition
EPB	Earthquake-prone Building
EQ	Equipment
ESD	Environmentally Sustainable Design
ETT	Exercise Tolerance Test
EX	Existing
FF&E	Furniture, Fixtures & Equipment
FM	Facilities Maintenance
GDA	Gross Departmental Area
GFA	Gross Floor Area
GP's	General Practitioners
HDU	High Dependency Unit
HVAC	Heating, Ventilation, and Air Conditioning
IBC	Indicative Business Case
ICU	Intensive Care Unit
IIG	Infrastructure and Investment Group, Te Whatu Ora
IIG IDF	IIG Investment and Delivery Framework
IL	Importance Level
IL4	Importance Level 4
IMPB	Iwi Māori Partnership Board
IO	Investment Objective(s)
IOC	Integrated Operations Centre
IPB	Inpatient Building
IPU	Inpatient Unit
IT	Information Technology
L&D	Learning & Development
LINAC	Linear Accelerator (Radiotherapy treatment machine)
LSF	Living Standards Framework
MAPU	Medical Assessment and Planning Unit
MCA	Multi Criteria Analysis
MDT	Multi-Disciplinary Team
MHSOP	Mental Health Service for Older Persons
MIC	Medical & Injury Clinic, aka "Urgent Care" – a primary healthcare facility provided by GP's

Term	Definition
MoC	Model of Care
MSP	Managing Successful Programme
MU	Medical Unit
NBS	New Building Standard
NPC	Net Present Cost
OPD	Outpatients Department
OT	Operating Theatres
PBC	Programme Business Case
PCSA	Pre-Construction Services Agreement
PHO	Primary Health Organisation
PMO	Programme Management Office
PMP	Programme Management Plan
PPP	Public Private Partnership
PSG	Project or Programme Steering Group
RHRP	Regional Hospital Redevelopment Programme
SCBU	Special Care Baby Unit
SMP	Site Master Plan
SRO	Senior Responsible Owner
TBIG	The Building Intelligence Group
TLA	Territorial Local Authorities
WST	Workforce/System Transformation

Investment summary

Investment details

Details	
Project name	New Dunedin Hospital Inpatient Building
Project ID	10025
Crown Manager/	Evan Davies
Project Director	Tony Lloyd
Project Manager	Kieran Reilly
Risk Profile Assessment (RPA)	High

Summary information

Checklist	
Investment type	☐ Facility ☐ Equipment ☒ Infrastructure ☐ Data and Digital ☐ Other (specify)
Location	Dunedin
Project drivers	☐ Growth/capacity ☒ Replacement ☐ Quality of service delivery/service levels
Summary of investment	Proposed investment in a new Inpatient Building to rep replace key services currently provided in the 1960s Clinical Services Block and 1980s Ward Block that are not economic to renovate or refurbish.
Infrastructure Investment Plan	☒ Yes ☐ No
Previous business cases and approvals	Indicative Business Case for Dunedin Hospital - 2017. Interim Detailed Business Case - August 2020. Final Detailed Business Case - April 2021
Proposed capital funding sources	☒ Health Capital Envelope (insert HCE amount) ☐ Baseline (insert amount) ☐ Other (specify source and insert amount)
Proposed ongoing operating funding sources	☒ Baseline (insert amount) ☐ Other (specify source and insert amount)
Delivery timeframes	Start: 1 July 2025 End: 17 October 2030 plus a defect liability period of 1 year.

CONTENTS

1 Executive Summary

1.1 Purpose

This Implementation Business Case for the Inpatient Building at New Dunedin Hospital seeks formal approval from Cabinet to:

- Finalise the contract with CPB Contractors Pty Limited (CPB) for the construction of New Dunedin Hospital Inpatient Building at a value of s9(2)(b)(ii)
- s9(2)(b)(ii)
- Authorise the Crown Manager to sign the contract with CPB.

1.2 Introduction

The key driver for this investment is that critical clinical buildings on the existing Dunedin Hospital campus are end-of-life, uneconomic to refurbish, and require replacement with a new hospital. Construction of a new 71,757m^2 Inpatient Building in central Dunedin will replace key services currently provided in the 1960s Clinical Services Block and 1980s Ward Block

The New Dunedin Hospital (NDH) programme was established to deliver the investment through three workstreams:

Facilities workstream

a) An **Outpatient Building**: this is presently being built by Southbase and will be operational in late 2026.

b) An **Inpatient Building**: enabling works to have been completed and foundation piling is underway. CPB contractors is the preferred provider and have been engaged on a Letter of Intent signed 30 June 2025 with the intention to award a main construction contract, subject to Government approval of this Implementation Business Case. A Crown Manager was appointed by Ministers in mid-June 2025, who is responsible for the delivery of the inpatient facility, including confirming the procurement approach and finalising the construction contract of the Inpatient Building.[1]

Digital transformation workstream

The Digital transformation workstream roles is to ensure that NDH has the required data and digital systems. This workstream was not included in the scope of the 2021 Detailed Business Case and is taking a separate business case pathway. s9(2)(b)(ii)
s9(2)(b)(ii)

Workforce transformation workstream

The Workforce transformation workstream role is to ensure that NDH has the required workforce and models of care embedded to realise the benefits of the facility. No funding was included in the scope of the 2021 Detailed Business Case and will instead be progressed by regional prioritisation processes, the Health New Zealand | Te Whatu Ora (Health NZ) Funding Committee and Health NZ Board. This work is underway through the Southern Operational Readiness Team.

[1] Further information on the accountabilities is outlined in the Management Case. The Crown Manager, Project Director are only responsible for the delivery of the construction of the Inpatient Building, not the Outpatient Building or the Workforce or Data and Digital workstreams

The focus of this Implementation Business Case is construction of the 71,757m2 Inpatient Building at the new Dunedin Hospital site (former Cadbury's factory). Health NZ is now ready to enter a main construction contract for the building which is expected to reach practical completion in October 2030 prior to operational commissioning.

A separate business case process will be progressed covering the Digital Services requirements and WOLC costs for Southern by the end of 2025.

The Implementation Business Case outlines the five cases for the proposed investment, the process followed to select the recommended preferred supplier(s) for the preferred option, and sets out the proposed commercial and management arrangements to deliver a new Inpatient Building for the NDH.

1.3 Work completed to date

The Outpatient and Inpatient buildings were originally managed by the Ministry of Health as one consolidated project; they have since been separated into two construction projects within the appropriated budget (the Outpatient Building governed by Health NZ (HNZ) and the Inpatient Building governed by the Crown Manager).

An Indicative Business Case for Dunedin Hospital was approved by Cabinet in July 2017. This was followed by Cabinet Approval in Principle to the Detailed Business Case in August 2020 [CAB-20-MIN-0413]. The Final Detailed Business Case (DBC) was approved in April 2021 [CAB-21-MIN-0124]. The Implementation Business Case for the Outpatient Building was approved in May 2022 [HR20220221].

At the time the Final DBC was approved a new Executive Steering Group was put in place.

Since the DBC was approved:

- CPB was appointed as the preferred contractor for the Inpatient Building under an Early Contractor Engagement Agreement in October 2021 following an open tender approach to market.
- Responsibility for the NDH Project transferred from the Ministry of Health to Health New Zealand (Health NZ) in June 2022 including the land acquired for the new hospital campus (Cadbury and Wilsons Blocks in central Dunedin).
- Responsibility for the Digital and Transformation Programmes transferred from Southern DHB to Health NZ in June 2022.
- Health NZ replaced the Executive Steering Group with a Project Steering Group led by an Independent Chair.

Cabinet directed a number of additional assurance requirements including a one-off externally led review of the NDH project, appointment of a Specialist Ministerial Advisor to the project, and requiring the NDH project to report to the Infrastructure and Investment Ministers (addressed in the Management Case).

- The Project Steering Group has now been replaced with a Crown Manager (June 2025).
- A Letter of Intent to award the contract for the Inpatient Building to CPB was signed on 30 June 2025. This allows for the commencement of certain off-site procurements, site enabling works and shop drawing activities which maintain programme. This does not guarantee award of the Contract to CPB.

1.4 Strategic Case

The expected outcomes and benefits to Southern's patients and workforce remain the same:

- Modern, fit-for purpose facilities created that can deliver modern models of care.
- Increased capacity, including the number of operating theatres.

There will be improved overall performance in other areas including:

- Improved acute service resilience and responsiveness.
- Improved building performance and a reduced environmental impact.

There have been several significant changes and challenges since Cabinet approved the Detailed Business Case in April 2021, particularly the overall cost escalations linked to the chosen building site, the post-Covid-19 Dunedin market context, and inflationary pressures.

Though significant, these challenges and changes have not materially altered the underlying strategic case for change: that the current Dunedin hospital is at the end of its economic and serviceable life, cannot be economically redeveloped, and must therefore be replaced with a new hospital.

1.5 Economic Case

The preferred option remains an Inpatient Building on the former Cadbury Factory block and an Outpatient Building on the former Wilson Parking site.

As the Outpatient Building is presently under construction, and the Inpatient Building design is progressing, it would no longer be feasible and/or economic to shift to any of the other options considered in the 2021 Detailed Business Case.

1.6 Commercial Case

A change since the Detailed Business Case is the shift from a Fixed Price Lump Sum delivery model (which was recommended in the Detailed Business Case) to a Collaborative Delivery Agreement mode within the standard NZS3910 contract. It has changed the way the Crown and contractor will engage with each other throughout the delivery phase, the way risk will be more equally shared, and the way that the total estimated construction cost is developed.

The new model has brought forward the required timing for contract signature to allow the contractor to start ordering long lead items, commence shop drawings and lock in the major subcontractors. s9(2)(b)(ii), s9(2)(f)(iv)

The Collaborative Delivery Agreement brings several advantages and will mitigate a number of risks related to the Dunedin market context. This form of delivery has been employed successfully in some Australian public sector projects. The form of contract will allow the project risk profile to be jointly monitored with both parties incentivised to eliminate risk and realise opportunities in a timely manner.

1.7 Financial Case

With the appointment of the Crown Manager for the Inpatient Building the project budgets for the Inpatient and Outpatient buildings are now being managed separately.

s9(2)(b)(ii)

1.8 Management Case

Following the establishment of Health NZ in 2022 a Project Steering Group (PSG) replaced the former Executive Steering Group and was responsible for the delivery of the Inpatient and Outpatient facilities, digital transformation and workforce transformation.

In June 2025 responsibility for project management and governance transferred from Health NZ's Infrastructure and Investment Group (IIG) to Evan Davies as Crown Manager. The Outpatient Building continues to be managed by HNZs Infrastructure and Investment Group (IIG).

The Minister of Health considered a Crown Manager was required to ensure that Health New Zealand meets its obligations to deliver the New Dunedin Hospital Inpatient Building Project. The key functions of the Crown Manager include:

- overseeing the delivery of the New Dunedin Hospital project and ensuring all appropriate measures are in place to support delivery in line with the agreed contractual arrangements, including strengthened client-facing leadership in Health New Zealand for this project.
- deliver the construction scope and programme as it relates to the Inpatient Building

- agreeing the approach for early works packages and procurement of long-lead items to maintain momentum on the programme.
- negotiating the final contract for the main works package of the Inpatient Building.

The Inpatient Building Project Director and project team will manage progress and maintain overall management of the project schedule, risk and issues, financial reporting, stakeholder engagement and escalations of any exceptions to the Crown Manager.

The project key milestones and high-level timeline are shown below.

Table 2: Key project milestones

Milestone /Critical Path	Date
Letter of Intent - date issued	**30 June 2025**
Preliminary Design complete –Design Reset.	**August 2025**
Developed Design complete.	**October 2025**
Pile Caps complete	**December 2025**
Detailed Design complete.	**January 2026**
Structure (Primary Steel) and Base isolators commencement	**July 2026**
Fitout commencement	**March 2027**
Façade commencement	**August 2027**
Façade finish	**November 2028**
Fitout complete	**May 2029**
Sitewide integrated commissioning completed	**September 2029**
PRACTICAL COMPLETION	**October 2030**
GO LIVE .	**February 2031**

1.9 Next Steps

Following approval of this business case:

- The Crown Manager will sign the contract with CPB.
- CPB will commence construction of the new Inpatient Building.
- Monthly reporting on status and progress will proceed through formal governance channels and reports including the Minister of Health.

2 Strategic Case

Dunedin Hospital employs 3,043 staff and provides tertiary/specialist adult and paediatric services for the lower part of Te Waipounamu, with a combined catchment of 341,000 people. One third of inpatients are from outside the Dunedin city catchment.

Dunedin Hospital is also a university teaching hospital with strong links to the University of Otago Medical School, Faculty of Dentistry, School of Physiotherapy and Pharmacy, and the Otago Polytechnic Schools of Nursing, Midwifery and Health Sciences.

2.1 Background

On 24 August 2020, Cabinet approved Option 5 as the preferred option for the New Dunedin Hospital Project (NDH) – an Inpatient Building on the former Cadbury factory site and an Outpatient Building on the adjacent former Wilson Parking Building site. [CAB-20-MIN-0413 refers].

Cabinet noted that the total budget for the NDH programme could exceed $1.4 billion, directed that a Final Detailed Business Case (DBC) be submitted on completion of a concept design and revised costing by February 2021, and directed that separate implementation business cases be submitted for each of the Outpatient Building (May 2021) and Inpatient Building (November 2021). The Final DBC was approved in April 2021 with a budget of $1.47 billion.

Following a design reset in 2022 Joint Ministers agreed to a reduced Inpatient Building option that still required an additional $110m of Crown capital funding and a further $10m to resolve outstanding clinical risks from the changes. Cabinet subsequently approved a further $290 million tagged contingency in March 2024 that lifted the project budget to $1.88 billion. This was to enable HNZ to enter into a construction contract for the Inpatient Building and to cover estimated contingency costs. Additional assurance requirements included a one-off review of the project, and appointment of Specialist Ministerial Advisor

In September 2024 the Ministers of Infrastructure and Health announced the Government was seeking advice on two options for delivering the New Dunedin Hospital project within its existing funding appropriation. The results of a one-off independent review into the project undertaken by independent expert Robert Rust, former chief executive of Health Infrastructure New South Wales have since been released.

On 31 January 2025 Minister of Heath reconfirmed the former Cadbury factory as the site of the Inpatient Building for the New Dunedin Hospital Project.

2.1.1 Review the Case for Change

The Strategic Case for an investment in NDH, as set out in the previous Detailed Business Case (of 24 August 2020), largely remains the same. There is a need for investment based on the poor condition of existing clinical facilities and projected unsustainable service demand associated with an aging population.

The existing Clinical Services Block (CSB) and Ward Block that currently house Dunedin's hospital is beyond repair, and may fail operationally due to:

- a deteriorating physical environment that is eroding quality of care, creating safety risks and potential harm, and causing distress to patients and staff
- inflexible and inappropriate care facilities that restrict service capacity, cause delays and increase outsourcing costs

- care facilities that cannot absorb innovations, preventing efficiency gains and care improvements.

Dunedin's population is projected to grow at a higher rate until 2038, reaching 142,318, then return to a medium growth scenario.

Table 3: Projected growth in Dunedin's usually resident population

2018	2028	2038	2048	2058	2068
130,520	138,674	142,318	142,985	143,616	144,249

Source: DCC Post COVID-19 growth projections update

More significantly, Dunedin's population continues to age, with 21% of the population projected to be 65 years or over by 2028.

Table 4: Dunedin's age groups over time

Age group	2018	2023	2028	2033	2038	2043	2048
65 years and over	16%	18%	21%	22%	23%	24%	23%
45 to 64 years	25%	23%	21%	20%	19%	19%	19%
25 to 44 years	23%	22%	22%	23%	23%	23%	23%
25 years and under	36%	37%	36%	35%	34%	34%	34%

Source: DCC Post COVID-19 growth projections update

Dunedin Hospital currently has 396 physical overnight beds (staffing 329). With no change in facilities or models of care, the hospital would need 451 beds by 2033, 513 by 2043.[2]

The proposed investment, allowing more efficient care, will provide 351 beds on opening, with capacity to expand to a designed 404 beds over time.

Dunedin Hospital is the tertiary hub of Otago and Southland. The population of this region is increasing, particularly in Central Otago. As regional services develop, Dunedin Hospital is expected to remain the hub hospital, delivering specialist services to the wider regions.

2.1.2 Changes & Challenges since the Detailed Business Case

While the high-level case for an investment remains the same as previous business cases, the NDH programme has faced a number of significant changes and challenges since Cabinet approval of the Detailed Business Case in April 2021:

Site selection: extraordinary cost premiums have been associated with land purchase in central city location, demolition costs, contamination (as a former industrial site), archaeological excavations of the pre-1900 European Settlement site, piling difficulties as it was part of the old shoreline, and access issues due to it being located between State Highway 1 North and South.

In the period since the Detailed Business Case, the economic climate has changed significantly, resulting in a global shift in the construction sector's appetite to take on the traditional contracting model with a large degree of project risk. Construction cost escalation from the pandemic has yet to fully abate and was not accounted for in the Detailed Business Case. In 2024 Te Waihanga –

[2] Source Detailed Business Case section 2.3.3 using data sourced from Jacobs, Johnstaff, CCM Architects 2018.

Infrastructure Commission reported construction cost inflation since Covid 19 as 27%. Cost inflation for NDH was 24%, indicating a high level of prudence in the project.

Delivery of the Outpatient building using a traditional Fixed Price Lump Sum model in the post-Covid setting has revealed Dunedin as an unattractive market for contractors and sub-contractors delivering large scale projects. This resulted in significant cost increases and delays. The direction to fast track the Outpatient Building led to shortfalls in procurement leading to costly increases in a volatile and constrained market (addressed in the Commercial Case).

s9(2)(b)(ii)

The combination of factors outlined above prompted the change to the contractual delivery model (addressed in the Commercial Case).

Further cost escalations saw the Minister of Health seek Cabinet approval for additional funding of $290 million in 2024 so the project could continue to the agreed scope and timeline. Cabinet approved that this sum be held in tagged contingency, noting that prior to entering into a construction contract with its preferred contractor (CPB), Health NZ must receive approval of this Implementation Business Case from the Minister of Health and the Infrastructure and Investment Ministers (addressed in the Financial and Management Case).

Cabinet also directed a number of additional assurance requirements including a one-off externally led review of the NDH project, appointment of a Specialist Ministerial Advisor to the project, and requiring the NDH project to report to the Infrastructure and Investment Ministers (addressed in the Management Case).

Though significant, these challenges and changes have not materially altered the underlying strategic case for change: that the current Dunedin hospital is at the end of its economic and serviceable life, cannot be economically redeveloped, and must therefore be replaced with a new hospital.

They have however brought about substantive changes to governance, the contractual relationship between the Health NZ and the eventual contractor, including the mechanisms for estimating and negotiating costs, for allocating and managing risk, for managing further cost increases, and for day-to-day project management.

2.1.3 Strategic context and investment objectives

The following investment objectives were developed for the Detailed Business Case and remain unchanged.

Table 5: Investment Objectives

Investment objective 1	**Create the ability to adapt through responsive infrastructure and capability that supports disruptive health system change**
Existing Arrangements	Factors including design, configuration and condition of the existing infrastructure hinder the roll out of modern models of care which are required to improve efficiencies and effectiveness. The current state of buildings means there is limited resilience to major events.
Health NZ needs	Need hospital infrastructure that can flex to accommodate future changes in technology, service models and capacity. NDH needs to be resilience and able to respond to future changes and events, include pandemic outbreaks and catastrophic diseases.

Investment objective 2	Optimise use of total health system resources
Existing Arrangements	Patient flows are highly inefficient with inconsistent, highly variable processes and pathways, interrupted care and repetitive and duplicated efforts. This results In delays in providing highly quality treatment. There are workforce capacity constraints across health specialities. There is inadequate investment in innovate models and tools to optimise use of resources, and insufficient uptake of tools when introduced.
Health NZ needs	Encourage staff innovation. Workforce planning including looking for roster efficiency and extending workforce to work under scope and possible labour substitution (e.g. greater used of Nurse Practitioners). Have an aspirational zero target for procedures. Coordinate surgical lists and theatre capacity, with ICU and bed capacity. Live within funding provided

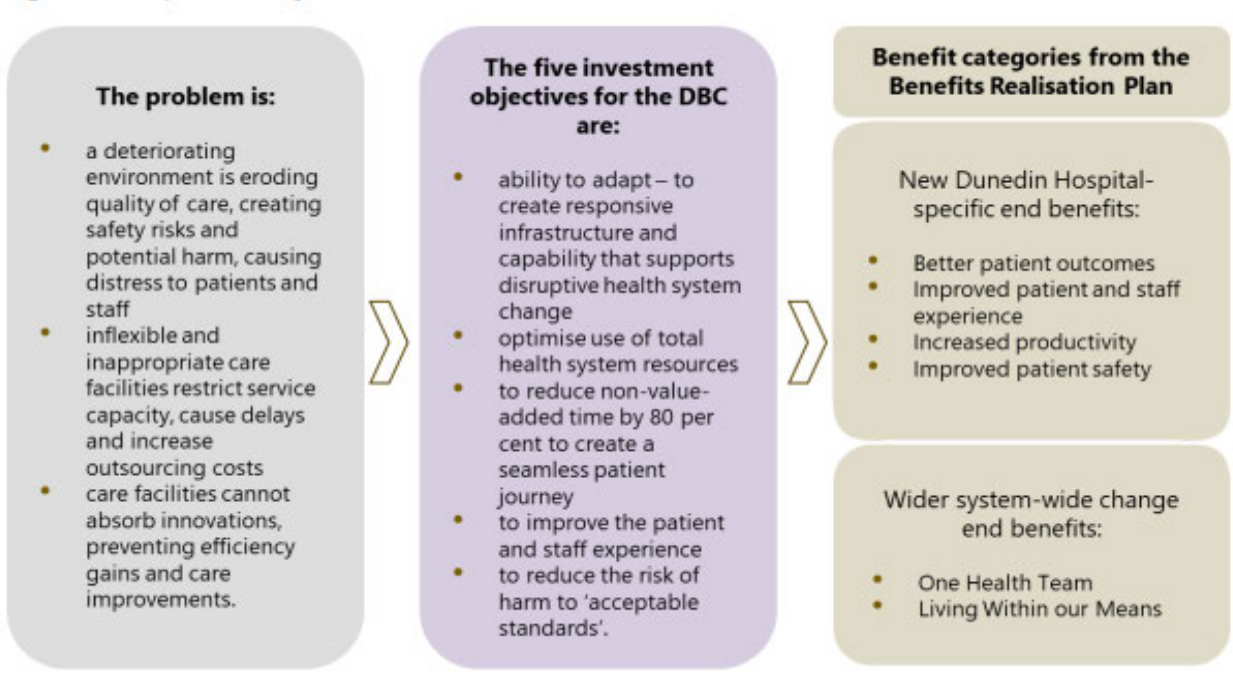
Investment objective 3	Reduce non-value-added time by 80 per cent to create a seamless patient journey
Existing Arrangements	Poor flows arising from current layouts result in interrupted care with unnecessary and repeating testing. Inadequate systems and facilities result in duplication and inefficiencies. Referrals from rural providers are poorly coordinated leading to inefficiencies
Health NZ needs	24/7, 365 service provision where appropriate. Productivity improvements to reduce process delays and handovers. Efficient flow from admission to discharge

Investment objective 4	Improve the patient and staff experience
Existing Arrangements	Poor staff morale and engagement. Lack of patient privacy. Poor working conditions. Cancellations, delays and unnecessary testing. Poor patient flows
Health NZ needs	Improve community confidence in the hospital. Improved staff experience. Patient experience surveys – improve performance to show hospital either at or above national average.

Investment objective	Reduce the risk of harm to acceptable standards
Existing Arrangements	Delays and interruptions in timely care. High workloads leading to elevated risk of harm. Facilities that neither fit for purpose or compliant.
Health NZ needs	Eliminate events that have potential to cause serious harm that is wholly preventable e.g. wrong site surgery. Zero falls

The benefits that are expected from the investment and how these correspond to the objectives and original problems are illustrated below:

Figure 1: NDH Problems, investment objectives and the benefits expected



A copy of the Investment Logic Map for the proposed investment is unchanged from the Detailed Business Case and is attached in Annex 2.

2.1.4 Strategic alignment

The proposed investment aligns with national, regional and sector strategies including those detailed in the table below

Table 6: Strategic alignment

Area of strategic alignment	How the proposed investment is aligned
Pae Ora (Healthy Futures) Act 2022	The purpose of the Act is to provide for the public funding and provision of services in order to— (a) protect, promote, and improve the health of all New Zealanders; and (b) achieve equity in health outcomes among New Zealand's population groups, including by striving to eliminate health disparities, in particular for Māori; and (c) build towards Pae Ora (healthy futures) for all New Zealanders. NDH with improved facilities will help to deliver on these objectives, particularly if the chosen sites are in communities with high at-risk populations.
Te Pae Tata Interim New Zealand Health Plan 2022	This plan outlines the first steps towards a health system that better serves all New Zealanders. Additional capacity helps to deliver on the objectives set out in Te Pae Tata.
Te Tiriti o Waitangi	NDH will assist with system flow and help reduce wait times in some areas. This will help to provide improved and equitable service delivery to reduce persistent Māori health inequity.

Area of strategic alignment	How the proposed investment is aligned
Government Policy Statement on Health 2024-2027	The policy statement has 5 priority areas. 4 of these areas **(access, timeliness, quality, infrastructure)** are aligned to this initiative by uplifting capacity and/or allowing remediation or redevelopment work to take place at some hospital sites. Improved infrastructure contributes to timely access to quality healthcare.
National Health Strategy	The NZ Health Strategy has two long term goals: **Achieve health equity and Improving health outcomes.** Additional capacity will help contribute to these goals.
Government Health targets	The proposed investment is aligned to 3 of the 5 health targets: **Faster cancer treatment and** **shorter wait times for elective treatments** – by having beds in wards available for patients before and after treatment (lack of available space in wards can be barrier to obtaining treatments) Shorter stays in emergency departments – by having space for patients to be admitted rather than held in ED due to lack of space
Te Pae Tata Interim New Zealand Health Plan 2022 (NZHP) Carbon Neutral Government Programme A Zero Carbon Road Map for Aotearoa's Buildings Climate Change Response (Zero Carbon) Amendment Act 2019	Climate change is a priority in NZHP, which sets out a series of actions required by Health NZ including setting and monitoring emissions reduction targets, understanding and reducing operational and embedded carbon emissions, reducing category 1 and 2 emissions by 25 per cent by 2025, and including environmental outcomes and sustainability and climate resilience principles in all procurement contracts. All new large-scale Health NZ infrastructure investments are required to meet the New Zealand Green Building Council 5-Star Green Star accreditation standards. The investment will be designed with environmental sustainability and climate resilience principles in mind. It will improve the hospital's ability to operate sustainably without degrading the environment. The project will make all reasonable efforts to contribute to environmental sustainability, climate resilience, and emissions reduction objectives and seek low-carbon design and construction processes.

2.1.5 Contribution to the Government Health Targets

In March 2024, the Government released five targets for the health system. The proposed investment in interim relocatable inpatient units is strongly aligned to two of these targets and will have a positive impact on two other targets.

Table 7: Government health targets relevant to NDH development

Government Health Target	Contribution of the New Dunedin hospital redevelopment to the Health Targets
Shorter stays in emergency departments	NDH will assist with better patient flow across the hospital and also the extra capacity will help with 'bed block' (insufficient ward beds) that are a major contributor towards length of stay in emergency departments

Government Health Target	Contribution of the New Dunedin hospital redevelopment to the Health Targets
Shorter wait times for elective treatments	The improved layout and resulting patient flow throughout the hospital will improve wait times. Increasing overall capacity over time will mean that one of the constraints for elective treatments are removed (i.e. less treatments cancelled due to lack of inpatient beds)
Shorter wait times for first specialist assessment	There are shortages of some specialists in NDH. Having a more attractive and safe working environment will aid with recruitment

2.1.6 Alignment with Health New Zealand's Health Infrastructure Plan

NDH is a top ten priority project in Health NZ's Health Infrastructure Plan (HIP), the physical component of a ten-year roadmap for health infrastructure investment. Investment priorities were based on an assessed level of asset failure risk, investment readiness, and alignment with the National Clinical Services and Campus Plan (NCSCP), which sets out a future-plan for service delivery design and capacity growth. The HIP was agreed in principle by Cabinet in early March 2025, subject to Budget decisions and business case approvals [CAB-25-MIN-0051].

This proposed investment is focused on the Inpatient Building for Dunedin hospital. Other potential investments in other areas such as Data and Digital investments across the Southland region, Pathology, or Clinical Sterilisation Services are outside of this proposed investment.

2.1.7 Scope

The scope of this Implementation Business Case is confined to the facilities workstream and construction of the Inpatient Building specifically. The Financial Case includes the capital and operating costs required to operate the building from 2031.

The Inpatient Building will consist of 11 floors with a total GFA of 71,757m^2 including a helipad and the following departmental spaces.

Table 8: Inpatient Building Inpatient Building

Building	Department
Inpatient Building	23-Hour Unit
	Acute Dialysis Unit
	Acute Radiology
	Assessment & Planning Unit
	Back Of House Services - Inpatient
	Cardiac Interventional Suite
	CETES Clinical Engineering
	Collaborative Workspace - ICU Shell
	Collaborative Workspace - Support Services
	Emergency Department
	Emergency Psychiatric Service
	Food Services
	Front Of House - Main Hospital Entry

	Helipad
	ICU - 30 Beds Including HDU
	Information Services
	Integrated Operations Centre
	IPU Adult Medical - Surgical 7
	IPU Adult Medical - Surgical 8
	IPU Adult Medical - Surgical 9
	IPU Cardiac High Acuity Unit
	IPU Children's - Paediatric Assessment Unit
	IPU Haematology, Oncology & Med Surgery
	IPU Inpatient Shell Space
	IPU Medical High Acuity Unit
	IPU Mental Health Services Of Older People - Medical Unit
	IPU Rehabilitation - Medical Unit - East
	IPU Rehabilitation - Medical Unit - West
	Maternity & Day Assessment Unit
	Mortuary
	Multi-Faith Centre
	NICU
	Nuclear Medicine
	NZ Blood Service - Blood Bank
	Operating & Interventional Suite
	Pharmacy
	Primary Birthing Unit
	Public Amenities - Inpatient
	Retail And Staff Café
	Satellite Radiology
	Security
	Staff Amenities
	Sterile Services Unit

Scope, as before, includes a 310m^2 "red" bridge between Inpatient and Outpatient Buildings to facilitate the movement of clinical staff and supplies.

With removal of building services on the Bow Lane site, a connection from the Inpatient Building to the edge of the boundary for a supply of heat from the existing District Energy Scheme will be provided. Negotiations for a supply of heat from the existing district energy scheme are currently being progressed.

As before, commercial spaces including the retail spaces, café, mortuary, kitchen and NZ Blood Service will be procured and fitted out for opening.

In a change from the DBC, and as a result of the 2024 'reset' and selection of option 2.3a, clinical spaces will be fitted out in stages. Stage 1 capacity is provided on opening of the Inpatient Building, aligned with more recent 2024 HNZ National Bed Modelling. Additional beds and

theatres can be brought on after opening to meet future demand, (Refer Annex 3: Capacity Table). Delayed fit out has been further applied to include sterile services, nuclear medicine and workspaces. There has been a permanent reduction in beds in rehabilitation services and Mental Health Services of Older People, with the new modelling assuming greater delivery of care to these populations in the community.

The empty Level 6 space provides for future growth in healthcare provision and there are areas shelled ready for a CSSD and nuclear medicine. HNZ will progress these as separate investment or operational decisions.

Table 9: Floor layout

Department	Location	Area
Retail North	Ground	33m²
Retail South		114m²
Retail (blue core bridge)	Level 1	25m²
Kitchen		933m²
Cafe		447m²
Acute radiology – MRI		69m²
Acute radiology – CT		67m²
Nuclear medicine		674m²
NZBS (fitout by others)		255m²
Mortuary and Central courtyards		154m²
OIS – Pod 1 Theatres	Level 2	295m²
CSSD	Level 3	548m²
ICU	Level 4	605m²
Collab in red core		55m²
Cold shell – balance of Level 4 North		1,500m²
Primary birthing	Level 5	493m²
IPU cold shell (1,652 m² + 3,203m²)	Level 6	4,855m²
		11,122m²

The Detailed Business Case was premised on 250 car parks being provided with the new Inpatient and Outpatient Buildings. In November 2023 the expert consenting panel granted resource consents for the New Dunedin Hospital Inpatient Building with the following:

a. Visitor parking: 37 car parks (including pick-up / drop-off spaces)

b. Staff parking: 29 car parks (including Emergency Services and Funeral Director)

c. Ambulance: 8 spaces

d. Loading / other bays: 10 bays (including Mortuary, VIE and Lithotripsy)

e. Mobility: 10 spaces

f. Staff cycle parking (130), visitor cycle parks (42), showers (10) and lockers (104) (serving the whole NDH).

s9(2)(b)(ii) frees up the existing carpark on Bow Lane (110 spaces). With the acquisition of land on the Wilson Block there will be 600 mostly on grade car parking spaces across the Dunedin campuses when the Inpatient Building opens.

2.1.8 Related Investments

Two other workstreams, outside of this business case are necessary to realise the benefits of this investment.

- **Digital transformation,** to ensure that NDH has the required data and digital systems. This was not included in the scope of the 2021 Detailed Business Case. s9(2)(b)(ii)

- **Workforce transformation,** to ensure that NDH has the required workforce and embedded models of care necessary to realise the benefits of the NDH, was also not included in the scope of the 2021 Detailed Business Case. This work is underway through the Southern Operational Readiness Team.

More broadly, enhancing care in the community, increasing ambulatory care, and optimising regional capacity will be critical enablers of the NDH.

In addition to the capital costs and funding allocated to NDH Inpatient and Outpatient Buildings, Cabinet has also agreed to consider related funding in other areas as outlined below:

Table 10 Cabinet decisions

Date	Cabinet Decision	Funding not allocated but noted
15 April 2021	Cabinet noted a sperate Detailed Business Case for investment in digital infrastructure will be prepared s9(2)(b)(ii)	s9(2)(b) s9(2)(b)(ii)
25 March 2024	s9(2)(b)(ii)	[redacted] s9(2)(b)(ii)

Other campus services which operate from Wakari Hospital (mental health services, and rehabilitation), cancer treatment services in the existing city centre site, and Orthotics and Prosthetics, are outside of the scope of this business case and will continue to operate as before.

2.1.9 Strategic risks

Many of the strategic risks that impact the achievement of the investment objectives remain valid from the Detailed Business Case. They have been updated to reflect the impact of the different reviews of the project and extended process for appointing a Main Contractor.

Table 11: Strategic risks

Summary	Potential failure(s)/ success(es)	Potential effect(s)	Current process controls/ Mitigations	Rating
Subcontractor reluctance to continue to negotiate pricing	Inability to give confidence that the project represents good value for money. Higher risk factored into subcontractor pricing.	Higher than anticipated construction cost. Potential programme delay. Losing key subtrades.	s9(2)(g)(i)	
Inability to agree acceptable commercial terms with CPB	Continued delay to commencing formal contract signing.	Significant programme delay. Increased cost. Market disinterested in bidding for the job.		
Project fatigue in face of uncertainty	Insecurity around project progression Repetitive Value Engineering (VE) processes/resets.	Loss of staff and replacement. Staff's wellbeing reduces. Needing to reduce opening day capacity to mitigate design changes and prolonged programme. Additional cycles of reengagement needed with clinical leaders to review changes.		
Delay in decision making exacerbates the cost increase and programme delay	The project in the current market is too expensive for the scope.	Further increase in cost and delay meaning even more cost and delay and therefore scope reduction.		

Summary	Potential failure(s)/ success(es)	Potential effect(s)	Current process controls/ Mitigations	Rating
Loss of project knowledge and clinical staff engagement through delays	Loss of significant IP that has been built up in relation to the project and the service needs of the region	High staff turn over and loss of IP. Increase cost to the project. Loss of morale.	s9(2)(g)(i)	

Further information on the risk management approach and key mitigations are contained in the Management Case.

2.1.10 Dependencies and constraints

There are three main dependencies that will need to be progressed separately to this Business Case to achieve the system wide benefits from the NDH development:

Table 12: Dependencies and Constraints

Dependency	Description
Digital transformation,	Digital transformation and IT upgrades are necessary to the successful implementation of the NDH project and obtaining the full productivity and other benefits. Digital transformation is being progressed as a separate workstream
Workforce transformation	Addressing current workforce shortages and future needs. Ensuring staff are working top of scope. Building target workforce models for new units or ways of working. Workforce transformation is separate workstream
Models of Care	Improved models of care including enhancing care and capacity in the community, increased use of ambulatory care, creation of new units optimising patient flow (e.g. the Day Procedures Unit, 23-Hour Unit, the Assessment and Planning Unit), adopting new digital enhancements. Achieving the benefits from improved models of care is linked to progression of the digital transformation strategy and workforce transformation.

There are five constraints that could impact or limit the implementation of the investment proposal for the Inpatient Building.

Constraint	Description
Funding	To date Cabinet agreed that the total capital budget for inpatient building is $1.88 billion. s9(2)(b)(ii) s9(2)(b)(ii) s9(2)(b)(ii)

Constraint	Description
Building site	Cabinet agreed that the site for Inpatient Building is on the Cadbury site and an Outpatient Building is on the adjacent Wilson Parking Building site The chosen site introduced cost pressures associated with land purchase and demolition costs, contaminated ground, archaeological surveys /excavations, piling difficulty, flood level risk, water table depth and access issues due to it being located between State Highway 1 North and South
Commercial capability	The Inpatient Building is a large construction project. There is limited capability to undertake a large project of this scale, particularly in a regional location such as Dunedin. There is also constraints around construction specialities to undertake the development.
Hospital – 'business' as usual	Health care that is being provided by Dunedin hospital will need to be able to continue without significant interruptions, while the NDH project and new models of care are introduced
s9(2)(f)(iv)	

3 Economic Case

The Economic Case provides a brief overview of the preferred option and revisits the analysis that was set out in the Detailed Business Case since approved in March 2021.

3.1 Review of the options and assessment criteria

Following identification that Dunedin Hospital's critical buildings were at the end of their serviceable life, the 2017 Indicative Business Case shortlisted two options to take forward to a Detailed Business Case:

- a new hospital on a new site, and
- a new hospital on the Wakari site

In May 2018 the announcement by the Government that a new central city site had been purchased (the former Cadbury site), effectively ruled further consideration of the Wakari site.

3.1.1 Short list of options that were considered

The decision on the preferred option considered five shortlisted design options across two broad categories for the Cadbury site:

- **a single building** integrating acute and ambulatory services, but sited on different locations across the two city blocks
- **two buildings**, joined by bridge(s), providing some separation of ambulatory and acute services.

The preferred option (Option 5) was selected from the following five short-listed options:

Table 133: The key short-listed options

Options	Description
1. Single Building (Cadbury's site)	Single building on the Cadbury's site with Outpatient Building at the northern end of the Cadbury's site (that perform day procedures). Under this option the Outpatient part would be constructed first including a fit out for Day Procedures. The Inpatient Building area would be completed last with large floor plate connections to Day Procedures/ Outpatients at three levels
2. Two Building (Cadbury's site)	Under this option a Day Procedure building would be built on the northern end of the Cadbury site. The Outpatient Building would follow on the Wilson's site with bridge links between the buildings. The Inpatient Building would be constructed last with floor plate connections to Outpatients at three levels.
3. Single building (Wilson's site),	This option has the Outpatient Building at the southern end of Willson's site and would be a cold shell. Day Procedures would be fitted out to enable earliest delivery of services. The Inpatient Building would be done last with large floor plate to the Day Procedures/Outpatients across three levels.
4. Single building (St Andrews Steet)	Under this option the Outpatient Building will be delivered first at the southern end of the Wilson's sit to enable early delivery of Day Procedures, while Outpatient building will be left as a cold shell initially. The Inpatient Building would be complete last with large floor pate connections to Day Procedures/Outpatients at three levels across St Andrew Street

Options	Description
5. Inpatient Building (Cadbury's block) Outpatient (Wilson's block)	This option is a scaled version of the original option that was presented in the Site Master Plan with Outpatient Building at the southern end of the Wilson's site and the Inpatient Building at the northern end of the Cadbury's site. Under this option the gross floor area, following fine tuning the design and requirements, being reduced from 93,000 to an Inpatient Building of 71,757m^2 GFA and Outpatient Building of 13,391m^2.

3.1.2 The Detailed Business Case identified Option 5 remains the preferred option

The economic assessment in the previous Detailed Business Case determined that the Preferred Option to optimise value to New Zealand is Option 5:an Inpatient Building on the former Cadbury Factory block and an Outpatient Building on the former Wilson Parking site [CAB(20)-Min0413 refers].

Option 5 was assessed to provide the best value for money when considering urban context, project certainty, early delivery of day surgery, future expansion and precinct integration.

The NDH Project was not considered as a possible public-private partnership as part of the procurement options as agreed by Cabinet in April 2018 [CBC(10)Min0052 refers]

Option 5 was, and still is, the preferred option that optimises public value. It would no longer be feasible and/or economic to shift to any of the other original DBC options. The Outpatient Building is now one year away from completion.

The December 2024 'reset' involved a rapid re-look at feasibility of refurbishment of the existing Dunedin Hospital. In January 2025, the Minister of Health, again, reconfirmed the Inpatient Building on the Cadbury site as the preferred option.

3.1.3 Capacity changes since the 2021 Detailed Business Class was approved

As noted in the Strategic Case, there were no material changes to the agreed Investment Objectives. These updated assessment criteria were used to help inform the confirmation that Option 5 remains the preferred option. There have however been capacity changes including the numbers of inpatient beds, theatres, self-care/ambulatory rooms, imaging.

The following capacity table illustrates the capacity of the current Dunedin Hospital, the Detailed Business Case for the New Dunedin Hospital (NDH), new national point of care modelling, and the updated design reset as of 2025. The changes to design affect the Inpatient Building only.

- **Bed modelling**: Health New Zealand now uses a consistent nationwide approach to demand and capacity modelling for hospital and specialty services. Previously, individual modelling resulted in significant national variation across health facility planning. Applying the new modelling to NDH has resulted in approximately the same number of beds bas in the DBC but a change in the mix of bed types required, for example decreased ICU beds and increased medical surgical beds.

- **Flexibility and future-proofing:** Planning and designing contemporary health facilities needs to be future-flexible for changing models of care, new technology and growing populations. The design of NDH is "long life, loose fit", using standardisation of design to maximise future flexibility of each space. In addition, the NDH has future-proofed spaces so further beds or theatres, can be added to meet capacity demands as demand changes.

Table 414 Inpatient beds

Ward	Dunedin Hospital Current Built Capacity 2024	Dunedin Hospital Resourced Beds Snapshot 2024	Final Detailed Business Case (DBC) 2021	New National Point of Care Modelling 2024 2037/38 planning horizon	New Dunedin Hospital Operational 2031	New Dunedin Hospital Future-proofed capacity (as per demand)
Inpatient Beds (incl maternity, neonatal, transit, paediatric, geriatric mental health, rehab, medical and surgical, ICU/HDU	396	329	410 (incl. 10 cold shell)	387	351	404
New Model of Care 23-hour unit (same day beds)*	0	0	20	11	20	20
TOTAL Overnight Inpatient Beds:	**396**	**329**	**430 (incl. 10 cold shell)**	**398**	**371**	**424**

In addition to the changes in numbers of overnight beds there are changes in numbers of non-same day treatment areas as summarised below (outlined in more detail in Annex 3)

Table 15 5: Operating theatres, Outpatient care and treatment and Imaging

	Dunedin Hospital Current Built Capacity 2024	**Final Detailed Business Case 2021**	**New National Point of Care Modelling 2024** 2037/38 planning horizon	**New Dunedin Hospital** Operational **2031**	**New Dunedin Hospital** Future-proofed capacity (as per demand)
Operating theatres (inpatient and outpatient)	17 (+ 1)	28 (incl. 4 cold shell)	21	22	24
Outpatient care and treatment (includes consult and procedure rooms, specialty clinics, medical physiology labs, transit care)	Incomplete data - Outpatient activity currently occurs in a variety of spaces including dedicated outpatient clinic rooms plus offices.	129	76	126	126
Imaging (MRI, CT, Ultrasound, Fluoroscopy, xray and other imaging)	17	25 (plus 1 shell)	22	20	26

3.1.4 Benefits from the preferred option

The benefits of the preferred option remain similar to those outlined in the 2021 Detailed Business Case that was agreed by Cabinet [CAB-21-MIN-0124]. In addition to these benefits, that are benefits that relate to the Government health targets, and the redeveloped hospital will also have sustainability and environmental benefits.

3.1.5 Benefits of Option 5

Factoring in the Inpatient Building design reset, the updated overall package provided under Option 5 has been re-evaluated against the expected benefits in the Benefits Realisation Plan (Annex 5), and the other shortlisted options considered in the Detailed Business Case, to confirm that it still offers the optimal mix of benefits, costs and risks.

The NDH benefits realisation plan aligns closely with the Government Health Targets. The people, processes and technology enhancements facilitated by the NDH Project will help HNZ to progress towards meeting targets related to shorter wait times for elective treatment; shorter wait times for first specialist appointments; and faster cancer treatment.

Once the NDH IB goes live – and following the adoption of a wider change management programme – we expect to see material improvements in the shorter stays in the Emergency Department and improved immunisation rates across the Southern District.

The NDH will help support Southern to realise better health outcomes and improved operational performance. Regular reporting will be used to help identify where improvements can be made in the project to support this aspiration.

Further work is required to refine NDH benefit metrics relating to equity gains for Māori and Pacific communities that will be realised through the NDH. Practically speaking, measures are needed to track improved access to services in proportion to health need; equitable levels of service; equitable health outcomes; and support for the delivery of a Maori and Pacific workforce reflective of population.

The identified benefits, measures of these benefits and links to Government Health Targets for NDH are outlined below:

Table 16: NDH Benefits, Measures and links to Govt Health Targets

NDH Benefit	Key Measure	Link to Government Health Targets
Modern, fit-for-purpose facilities created	• Facility built to appropriate clinical • standards • Fewer patient harm events • Improved patient and • staff satisfaction rates • Services to support • whanau-based care • delivered • Improved accessibility • in NDH vs DPH	• Shorter wait times • for elective • treatment. • Shorter wait times • for first specialist • appointments. • Faster cancer • treatment. • Shorter stays in • the Emergency • Department

NDH Benefit	Key Measure	Link to Government Health Targets
Increased NDH capacity, including operating theatres	• Better reported access to ED, ICU/HDU and recovery spaces vs DPH • Increased diagnostic provision vs DPH • Increased theatre productivity • Day surgery productivity (interim • and final state)	• Shorter wait times for elective treatment. • Shorter wait times for first specialist appointments. • Faster cancer treatment. • Shorter stays in the Emergency Department.
Improved NDH acute service resilience and responsiveness	• Optimised clean and dirty flow separation • maintained • A facility better optimised to achieve • patient flow • NDH Pandemic response measures • implemented	• Shorter wait times for elective treatment. • Shorter wait times for first specialist appointments. • Faster cancer treatment. • Shorter stays in the • Emergency Department • Improved Immunisation • rates
Outpatients Building facilitating outpatients with coordinated services	• IL3 OPB built • Increased OP clinic • capacity vs DPH • Increased ratio of telehealth events to • Outpatient attendances	• Shorter wait times for elective treatment. • Shorter wait times • for first specialist • appointments. • Faster cancer • treatment.
Improved building performance / reduced environmental impact of NDH vs Dunedin Public Hospital	• Green Star 5* “Design and As Built” • Less reactionary maintenance • Building draft Environmental Performance Targets • Reduction in carbon footprint of NDH vs • DPH • Alignment with Mana Whenua sustainability principles maintained	• Shorter stays in the • Emergency • Department

The Inpatient Building design reset’s fundamental principle was to identify cost savings whilst avoiding/minimising reductions in clinical service capability. Given the main redesign impacts outlined above, the design reset is assessed to have a minimal to negligible impact on Option 5’s delivery of the above benefits.

Given difficulty in benefit attribution, choosing appropriate benefit indicators was not a precise science. Double counting of benefit savings is also a possibility that should be avoided. Benefit savings from other change programmes (e.g. the Digital Programme), are not included in the overarching Benefits Realisation Plan but successful delivery of these programmes is a critical dependency for the NDH project.

4 Financial Case

The Financial Case determines the funding requirements of the preferred option and demonstrates that the recommended deal is affordable. It provides an assessment of the estimated total cost of ownership and the overall affordability of implementing the preferred option.

s9(2)(b)(ii)

This budget does not include the cost of the Digital Transformation, and the Workforce Transformation programmes.

4.1 Funding allocations

In July 2017 Cabinet approved an Indicative Business Case for New Dunedin Hospital. At that time, NDH was estimated to cost between $1.2 to $1.4 billion [CAB-17-MIN-0397 refers}. Over time there have been several adjustments to funding allocations that were agreed in Detailed Business Case.

Table 17: Funding allocations

Date	Cabinet Decision	Funding allocated
19 April 2021	Final Detailed Business Case agreed funding [CAB-21-MIN-0124].	$1.470 billion
15 December 2022	Joint ministers agreed to value management Option B that requires additional funding of up to $110m of Crown capital funding for NDH as provisioned in Budget 22. [HNZ00008490 refers]	$110 million
6 April 2023	Additional funding of $10m to be provided from the *Day One Health System Capital – Contingency* to resolve outstanding clinical risks at NDH from the design reset [HNZ00015667 refers]	$10 million
25 March 2024	Increase in tagged contingency subject to Cabinet approval of the Implementation Business Case [CAB-24-MIN-0095 refers]	$290 million

There have been a number of factors which have driven the capital cost rise including[3]:

- **Challenging site selection** related to central city location, demolition costs, contamination (former industrial site), archaeological surveys /excavations on a pre-1900 European Settlement site, piling difficulties (part of the old shoreline), and access issues (located between State Highway 1 North and South).
- **Building Footprint.** The decision was made to build two buildings not one.

[3] As noted in advice to Cabinet in 2024 (supporting CAB-24-0095 minute)

- **Contractor attractiveness**. Dunedin poses challenges of remoteness, climate, and staff availability. Only one tender responded to the Outpatient Request for Pricing, with similarly low levels of interest from sub-contractors.
- **Construction inflation**. The impacts of Covid 19, the war in the Middle East and tariffs have had a significant impact on cost.

4.2 Forecast cost and financial summary

4.2.1 Capital costs

Capital cost of the New Dunedin Hospital project for Inpatients and Outpatients Buildings
s9(2)(b)(ii)

Inpatients Building capital costs

This business case is focused on the New Dunedin Hospital Inpatients Building. The capital cost of the Inpatients Building, including data and digital costs in the building, for the period of construction FY25/26 to FY30/31 is outlined in more detail below

s9(2)(b)(ii)

QRA results

A QRA was undertaken by Sapere. A summary of the results are shown below:

s9(2)(b)(ii)

s9(2)(b)(ii)

Cost of delay

The above calculations are the output of discussions around a line-by-line discussion around the cost ranges of various inputs in the foreseeable contracting environment based on the construction plan. To stress test the results Sapere looked at the possibility of a nine-month delay in the construction timeline. Such a delay would have implications for:

- Preliminaries and general (P&G)
- Escalation
- Consultants' fees

Their estimate of these costs is shown below

Table 21- Cost of delays estimate ($ millions)

Item	Forecast cost of delays
Preliminaries and general	s9(2)(b)(ii)
Escalation[4]	
Consultants' fees	
Total cost of delays	

s9(2)(b)(ii)

4.2.2 Operating costs

Operating costs of the Inpatient Building are incurred from 2030/31. The full year costs are incurred from 2031/32. There are no operating costs for the period 2024/25 to 2029/30 while the Inpatients Building is being constructed.

Table 22 Summary of the Incremental Operating Costs (nominal, note totals may not sum due to rounding)
s9(2)(b)(ii)

[4] We have assumed, conservatively, that all non-fixed items would increase by the long-run CGPI average. In fact, many items would still be procured at an earlier stage.

s9(2)(b)(ii)

Table 23 Implications of demographic (aging population and acute demand growth) on treatment volumes and staffing implications

Year	Dunedin hospital treatment volumes	Outsourced treatment volumes	Total	Percentage increases in treatments	Dunedin hospital Staffing (FTEs)	FTE change	FTE Percentage change
2020/21	36,080.0	1,273.0	37,353.0		s9(2)(b)(ii)		
2021/22	34,134.0	1,425.0	35,559.0	-5.4%			
2022/23	36,129.0	1,927.0	38,056.0	5.8%			
2023/24	35,974.0	1,622.0	37,596.0	-0.4%			
2024/25	36,928.0	2,211.0	39,139.0	2.7%			
2025/26	37,592.7	2,250.8	39,843.5	1.8%			
2026/27	38,269.4	2,291.3	40,560.7	1.8%			
2027/28	38,958.2	2,332.6	41,290.8	1.8%			
2028/29	39,659.5	2,374.5	42,034.0	1.8%			
2029/30	40,373.3	2,417.3	42,790.6	1.8%			
2030/31	41,100.1	2,460.8	43,560.9	1.8%			
Total 2030/31	**41,100.1**	**2,460.8**	**43,560.9**	1.8%			
Demographic uplift 2024/25 - 2030/31							
Uplift for Staffing NDH							
2030/31 NDH Staffing Model							

Note actual volumes used for 2020/21 to 2024/25. Projections for other years

Of this increase in FTEs over this timeframe, s9(2)(b)(ii) would have been expected to take place in response to demographic changes in the Dunedin, and Otago - Southland regions. This increase in FTEs would have been expected from demographic changes, and as such would have been expected to be funded from the Vote Health uplift in operational funding that is received each year.

4.3 Key Assumptions

The key assumptions that relevant to the costings are outlined below:

Table 24 Assumptions

Assumption	Value	Source and commentary
Real discount rate	2%	As per Treasury Guidance
Inflation	2%	
Wage growth	3%	
Demographic growth is not included	0.0% p.a	
Appraisal period	20 yrs	As per HNZ policy
GST and tax	Excl.	GST excluded. Standard PAYE, KiwiSaver, ACC Levy included.
IB Construction complete	Oct-30	
IB commissioned and operation	Feb-31	
Commissioning costs phased evenly in from 1 July 2030 to February 2031		
Depreciation – land and buildings	2%	Per annum
Depreciation – fit-out	5%	Per annum
Depreciation – clinical equipment	10%	Straight-line method based on useful life
Depreciation FF&E	10%	Straight-line method based on useful life
Depreciation ICT	20%	Straight-line method based on useful life
Total employed workforce ($m over appraisal period 2025/26 - 2044/45, nominal)	s9(2)(b)(ii)	Includes (where appropriate): cover, on-call, callback and penals.

Note: the annual workforce costs are the incremental costs in addition to current workforce costs

4.3.1 Funding

The funding for the capital costs of the Inpatient Building is a combination of Health Capital Envelope Funding and depreciation funding for capital, and anticipated funding for Health New Zealand for demographic changes and the extra capacity of the new Inpatients Building

Table 25 Additional funding required by year (nominal $000. note may not sum due to rounding)
s9(2)(b)(ii)

4.3.2 Endorsement

The financial modelling used in this Business Case has been endorsed by the Deputy Chief Financial Officer (Te Waiponamu) of Health NZ and the Southern Director of Operations.

[5] Includes s9(2)(b)(ii)

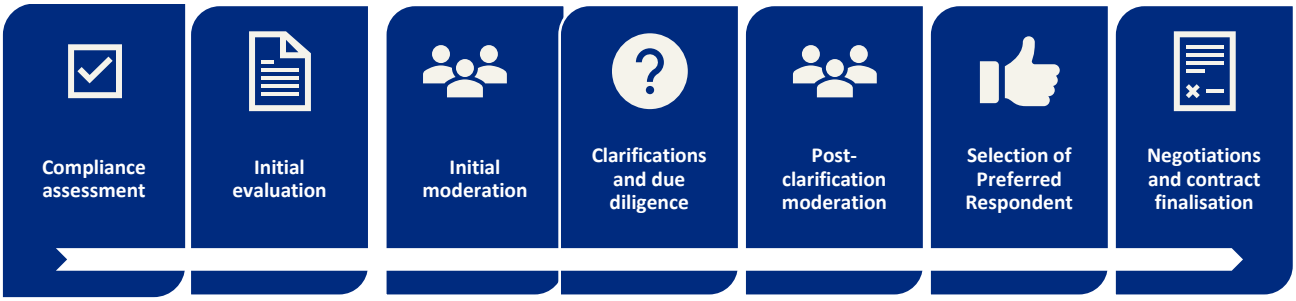
5 Commercial Case

This Commercial Case outlines the procurement process followed to select a preferred vendor. It also sets out the high-level contract arrangements for the solution and services and the main risks for the required solution and services.

5.1 Procurement strategy and approach

The Detailed Business Case approval included a Procurement Plan to approach the market for solutions and develop suitable draft contracts. The stages in the procurement are summarised in the diagram below:

Figure 1: Procurement approach



5.2 Procurement process

A Request for Tender (RFT) was issued on 26 November 2020 and closed on 18 March 2021. The procurement process followed complies with MBIE Rules of Procurement.

As the procurement occurred prior to the establishment of Health New Zealand, the Evaluation Panel consisted of representatives from the Ministry of Health, the New Dunedin Hospital Project Team, the Southern District Health Board, subject matter experts and an independent member of the Project's Technical Reference Group.

The tender for the Inpatient Building was released in November 2020, prior to the establishment of the Executive Steering Group. This means the Executive Steering Group has been required to make a decision based on a tender process and evaluation criteria they did not design or sign off on. As a result, the Executive Steering Group considered a broader range of options than is typical at this point in the procurement process, up to and including terminating the tender process and retendering when design is further along.

The Evaluation Panel reviewed all valid supplier offers against documented weighted criteria following the process described in the Procurement Plan. Details of the preconditions, non-weighted and weighted evaluation criteria for procurement are provided in Annex 7. At the conclusion of the process an Evaluation Report was endorsed by the Panel and submitted by the Evaluation Chair for endorsement by the Executive Steering Group and approval by the Senior Responsible Owner.

Extensive due diligence was undertaken as part of the evaluation process. Subject matter experts reviewed and provided advice on:

- legal structure, financial viability and due diligence disclosure statements, provided by PwC
- contract and contract works insurance policy, provided by Chapman Tripp and Marsh
- health, safety and wellbeing, provided by Avid Plus.

Probity was proactively managed throughout the procurement process. Oversight and real-time assurance on the Main Contractor RFP was provided by Independent Probity Auditor, McHale Group. McHale Group confirmed that the Main Contractor evaluation process was conducted in a transparent manner and in accordance with the RFP documentation, the Ministry of Health's procurement procedures, and good probity practice.

s9(2)(b)(ii)

s9(2)(b)(ii)

5.3 The preferred vendor

CPB Contractors (CPB) were selected as the preferred supplier in October 2021 to undertake an Early Contractor Involvement Engagement (ECE) phase, providing buildability advice on the Inpatient building design.

The Detailed Business Case assessed that including an Early Contractor Engagement phase – prior to converting to the Fixed Price Lump Sum delivery model – would reduce the project's design risk by establishing collaborative early engagement with CPB and key select trades on the process and design outcomes. In the event however, delays in the tender process limited the input CPB was able to have into the design process.

Following this phase the intent following the Detailed Business Case was to conclude with CPB a three phased separable portion Fixed Price Lump Sum contract for the construction phase of the project.

5.4 Change to a Collaborative Delivery Agreement

s9(2)(g)(i)

Following these concerns, a change was made to the shift from a Fixed Price Lump Sum delivery model (which was recommended in the Detailed Business Case) to a Collaborative Delivery Agreement model. It has changed the way the Crown and contractor will engage with each other throughout the delivery phase, the way risk will be more equally shared, and the way that the total estimated construction cost is developed.

The new model has brought forward the required timing for contract signature to allow the contractor to start ordering long lead items, with an exit clause in the contract to allow the Crown to subsequently withdraw should final terms and conditions be unacceptable.

The Collaborative Delivery Agreement brings several advantages and will mitigate a number of risks related to the particular Dunedin market context. This form of delivery has been employed

[6] Also included in the Sapere analysis Dunedin Hospital: Whole-of-life Cost Analysis(14 November 2024) Sapere commented on the literature around large construction projects and referred to analysis by Flybjerg and Garder, 2023 of 16,000 projects in 136 countries that showed more than 50% of projects exceeded their budgets and hospital budgets the average cost overrun was 29%

successfully in some Australian public sector projects. The form of contract will allow the project risk profile to be jointly monitored with both parties incentivised to minimise risk and realise opportunities in a timely manner.

Table 26: Difference between Fixed Lump Sum Delivery Model and Collaborative Delivery Agreement

	Fixed Lump Sum Delivery Model (FPLS)	Collaborative Delivery Agreement Model
Description	Under this arrangement the contract price is based on a single lump sum price for all of the works being agreed between the client and contractor prior to award of contract	HNZ and the contractor CPB have agreed a fixed price lump sum portion of the contract with the balance being delivered in an open book and transparent manner with risk/reward sharing between the parties. The contractor is incentivised to better the initial price.
Background	The FPLS model is a traditional approach and was the preferred approach in the Detailed Business Case due to the stable nature of the market at that time. HNZ pays for its high-cost certainty up front under the FPLS model is a higher total cost Total cost the contractor will factor in a significant additional sum as contingency against the risks they are contractually responsible for, such as construction materials, ground conditions, Geotech, and labour cost increases. irrespective of whether these risks eventuate or not, the HNZ pays the full price for them up front in its lump sum payment.	This approach allows for the contractor to fix the first portion of the contract based on fully designed components of the building at this time including ordering long lead items. Similar approaches have been employed successfully in some Australian public sector projects Point Wilson Waterside Infrastructure Remediation Project (A$300 million), the Riverina Project (A$1.2 billion), The Box Hill Hospital, Shepperton Hospital (A$250 million), Joan Kirner Women's & Children's Hospital and the Victorian Heart Hospital (A$550 million). In New Zealand, the base principles of this model have been used by Corrections to deliver complex prison projects (Auckland Women's Prison, Spring Hill Prison and Otago Prison).
Advantages	Are appropriate for projects where the requirements are well-defined at tender stage to enable the contractor to accurately price the project, and where significant post-contract changes are unlikely Typically, a reduced risk to the client but often associated with a premium being paid for this reduced risk.	Incentivises HNZ, the contractor, and designers to collaborate in project planning and design (with the contractor interrogating the design to reduce costs and improve project efficiency) better manage risks collaboratively and when problems arise focus on resolution rather than positioning for a dispute reward exceptional performance Flexibility of the model helps to manage any difficult coordination or interface issues Fully open book model with transparency of procurement and finance. Achieved by having HNZ representation in the CPB team.
Disadvantages	Fixed price lump sum model can falsely give the impression that the Crown's final costs for a project are well understood prior to signoff	High trust model - will require more active and responsive project management and governance by Health NZ.

	Fixed Lump Sum Delivery Model (FPLS)	Collaborative Delivery Agreement Model
	Needs a very well-defined scope of works with minimal changes.	There is some uncertainty about price on the non-fixed portion of the works.

The adopted collaborative delivery arrangement model for the NDH Project is a modification of a NZS3910 contract arrangement to allow for Health NZ's existing commercial arrangements with the design consultants (principally including Warren & Mahoney, BECA, and Holmes). The contractor has become for managing the performance and outputs of the design consultants for the Inpatient Building since signing the LOI. The contractor will largely be responsible for ensuring that the designs are properly coordinated and prioritised, but the responsibility for major design decisions that have already been made will remain with Health NZ.

5.5 Commercial arrangements

5.5.1 Exit clause and delays

The letter of intent with CPB contains an exit clause should this final Implementation Business Case not be approved or a suitable contract be negotiated.

5.5.2 Contract Payments

s9(2)(b)(ii)

5.6 Risk allocation and management

s9(2)(b)(ii)

s9(2)(b)(ii)

Table 6: Risks and mitigations

s9(2)(b)(ii)

s9(2)(b)(ii)

6 Management Case

The Management Case outlines how construction of the Inpatient Building will be managed.

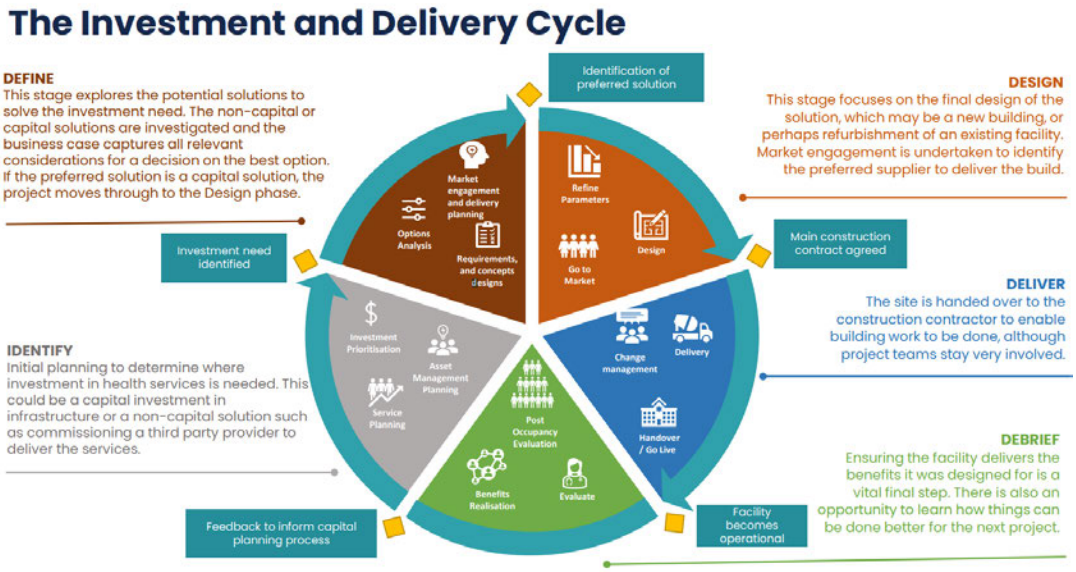
6.1 Revised programme management arrangements

In June 2025 a Crown Manager, Evan Davies was appointed by the Minister of Health to manage the implementation of the Inpatient Project. He is supported by a Project Board (whose membership is to be confirmed) and Project Director (Tony Lloyd) who has delivered large scale hospital infrastructure in the recent past.

6.1.1 Project management approach

The Inpatient Building Project Director will lead the delivery of the Inpatient Building in line with the IIG Project Investment and Delivery Framework Cycle. The Framework ensures the successful delivery of major health infrastructure that meets communities' needs. The project methodology is currently being used to support the delivery of the other regional hospital developments, which ensures that Health NZ can deliver these projects in a consistent, effective and efficient manner, while applying lessons learned over time.

Figure 2: IIG Project Framework Investment and Delivery Cycle



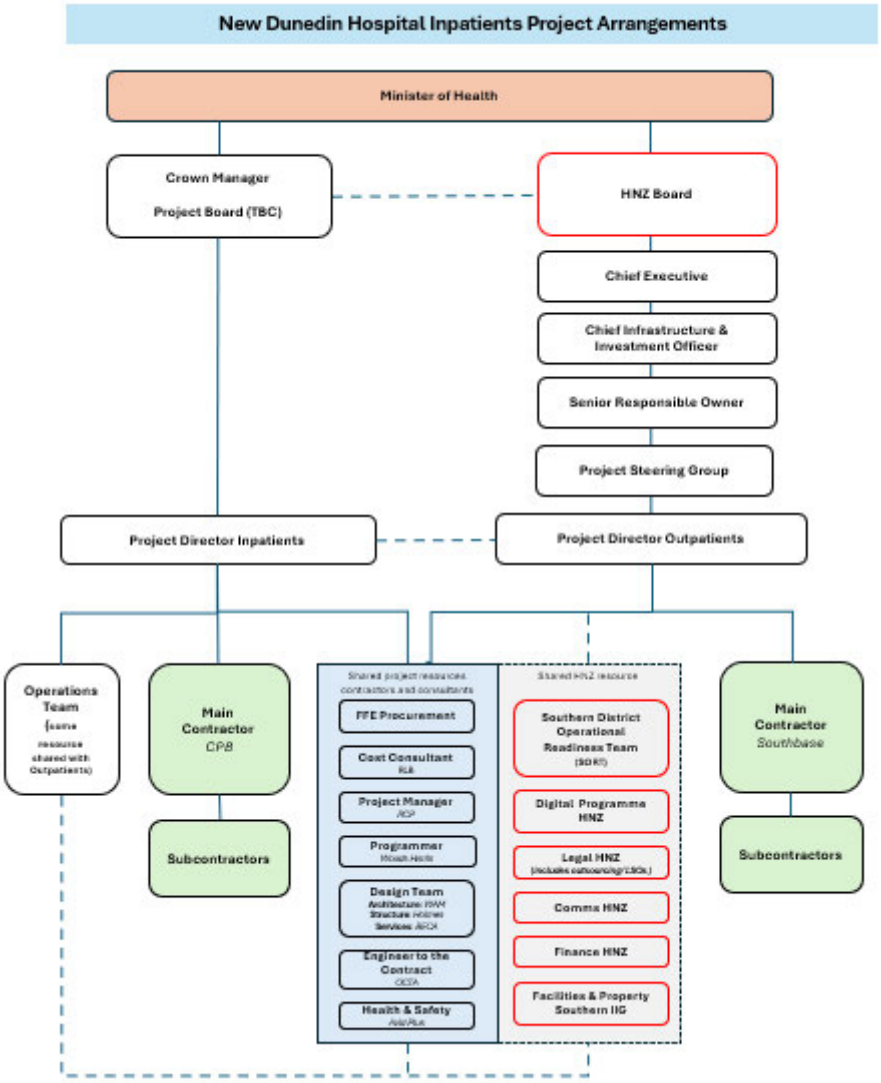
The Project Director will provide regular reporting to the Project Board, including:

- an overarching status report
- combined reporting and registers for:
  - key dependencies
  - risks
  - issues
  - external factors of influence
  - programme
  - budget
  - scope

6.1.2 Governance and personnel arrangements

The governance roles, responsibilities and reporting lines, are outlined in the following diagram along with key resources and consultants. While there is now a split between Inpatient and Outpatient Buildings the same consultants and shared HNZ resources continue to work on both projects :

Figure 3: Project Chart



The Crown Manager is responsible for governing the delivery of the programme. In summary, the governance is responsible for:

- **Quality**: That the deliverables are fit for purpose and deliver the desired benefits,
- **Risks**: That risks, issues and dependencies are effectively assessed, escalated and managed,
- **Time and Money**: That there are effective controls in place to monitor project timeline and budget, and any change requests are signalled early and transparently,
- **Performance**: That the delivery team has the capacity and capability required to support the project, and effective delegations are in place.

6.2 Stakeholder management plan

The current Stakeholder and Engagement Plan dated July 2025 is in the process of being updated and will be presented to the Crown Manager for endorsement.

In 2018 a Local Advisory Group which includes the Dunedin City Council, the former Southern District Health Board, Otago Regional Council, University of Otago and NZTA was formed to provide local insights and advice to the project. A similar group of key stakeholders has been formed in 2025 as the Southern Engagement Group (SEG). The membership and Chair arrangement is being confirmed in consultation with Dunedin City's Mayor.

Other key stakeholders include:

- **Clinical Transformation Group and leaders** – Representatives of Southern District's clinical leaders have given feedback throughout the design phases of the project and its resets. They will continue to be involved through the Southern Operational Readiness Team as needed.
- **Mana Whenua** Memorandum of understanding was signed with mana whenua representatives. They have been involved in the design of the Inpatient Building through their agents Aukaha were represented on the Project Steering Group. They will continue to be engaged with throughout the life of the project.
- **Southern mayors –** will be kept informed on progress
- **Wellsouth PHO**
- **Business South**
- **Southern Engagement Group**
- **Tertiary providers (University of Otago and Otago Polytechnic)**

6.3 Timeframe

The following summarises the key milestones underpinning CPBs contract offer. They reflect items on the critical path, and this has been communicated to relevant team members and leads. Key internal and external dependencies have been identified and incorporated into the programme. Given the scale of the project, CPB's Programme consists of thousands of individual lines. It is peer reviewed by the client side's programmer Woods Harris and deviations monitored as part of regular reporting. Changes in programme require a formal change request process to be completed.

Figure 4: Milestones

Milestone /Critical Path	Date
Letter of Intent - date issued	**30 June 2025**
Preliminary Design complete –Design Reset.	**August 2025**
Developed Design complete.	**October 2025**
Pile Caps complete	**December 2025**
Detailed Design complete.	**January 2026**
Structure (Primary Steel) and Base isolators commencement	**July 2026**

Milestone /Critical Path	Date
Fitout commencement	**March 2027**
Façade commencement	**August 2027**
Façade finish	**November 2028**
Fitout complete	**May 2029**
Sitewide integrated commissioning completed	**September 2029**
PRACTICAL COMPLETION	**October 2030**
GO LIVE / Operational date.	**February 2031**

6.4 Detailed project management plan

The detailed day-to-day control processes that will be used to manage delivery including governance, reporting, risk and issues management, dependency management, resourcing, scope and change, how the development methodology are detailed in the Project Management Plan.

This is a living document; the original was prepared in 2021. The current version (Revision 3) was updated earlier in 2025 and is in the process of being updated further to reflect the proposed agreement. It is listed in Annex 9 and is available on request.

6.5 Change management plan including workforce development

6.5.1 Impact assessment

Southern developed a Change Management Plan (CMP) (2024) that describes how to best harness meaningful Southern health system change facilitated by the development of the NDH. In the first instance, change necessary to facilitate a successful go live of the Outpatient Building (OB) will be prioritised, Operational readiness planning of the OB will also translate into key learnings to invest in the IB transition programme to follow later. Change management principles, strategies and approaches that are outlined in this plan are relevant to the entire NDH.

The detailed Benefits Realisation Plan was refreshed in line with recommendations from an Independent Quality Assessment (IQA) in 2021 (Annex 5). The key update was an alignment of key project outputs (e.g. building of the Inpatient Building) and NDH programme with the realisation of NDH Benefits.

- Early work to quantify operational efficiencies of, and savings realised by, the delivery of the NDH was undertaken when the DBC was drafted. Alignment with Health NZ's reporting framework is needed, including with Health NZ's reporting metrics currently being developed. Any savings identified will need to be directly attributable to the NDH (or its operation) and not double-counted elsewhere.

The following table summarises the initial change impact assessment.

Table 7: Summary assessment of organisational changes

Affected team/group	Number of people	Summary of impact
Medical	TBC	• Generalism – impact on workflow and require training and development to adopt new ways of working. This assumption will need to be tested as we progress. • s9(2)(f)(iv)
Nursing	TBC	• Change in building layout and location of equipment and supplies • Changes to staff workspaces and contemporary ward and clinical design • Admission process changes • New models of care/ways of working
Allied, Scientific and Technical	TBC	• Change in building layout and location of equipment and supplies • Outpatients model – TCU and new models of care/ways of working, which will likely require additional support from Allied, Scientific and Technical • Expanding to seven day a week services and increasing role in Emergency Department and Assessment and Planning Unit.
Support services	TBC	• New technology, processes and ways of working • Facilities and Property – new infrastructure to maintain, including in addition to Dunedin Hospital in the interim • Digital – increased digital complexity and increase in devices leads to changes in personnel and workflow • RFID/just in time stock management will affect Procurement and Supply teams' work programmes. Robots/Automated Guidance Vehicles will also need to be considered.
Administration	TBC	• Administration Co-Design/consolidated services – shift from physical departments to collaborative workspace will impact administration significantly.

Affected team/group	Number of people	Summary of impact
Primary and Community	TBC	• A key dependency that Primary and Community will need to absorb more activity, as per the NDH demand assumptions • s9(2)(f)(iv)
Patients and their whānau	TBC	• Change in focus towards ambulatory care. • All consumers' appointments related to their care plans are able to be booked in advance and updated as required. • Increased use of telehealth. • Digital solutions within facilities will enable electronic check-in and wayfinding. • Accessible, intuitive design.
Wider Dunedin community		• Fit for purpose NDH facility. • Care closer to home and delivered in a seamless and integrated way.

Change process management

The change management approach, reporting lines, roles and responsibilities are documented in detail in the Change Management Plan. This is a living document; the current version (as at June 2024) is listed in Annex 9 is available on request.

Workforce

The change management approach documents how Health NZ will address the organisational change impacts of this work, including preparing for, managing, and sustaining the change in support of the preferred option. This plan assists in determining the change actions that will need to occur, to address the identified impacts. It has been specifically updated for this revised PBC.

The guiding change principle is regular consultation with all who will be affected by the change, along with those who perceive the change may impact on them.

The proposed change will be of medium to high complexity: Health NZ's stakeholders are largely change ready, but the change activities will be significantly disruptive in an acute tertiary facility that will be operating as a wider health and education campus from when the Outpatient Building goes live in late 2026 until the Inpatient Building opens in 2031.

6.6 Dependency management

There are three main dependencies for the successful implementation of the NDH investment in an Inpatient Building as outlined below

s9(2)(f)(iv)

To address current and emerging pressures Health NZ has developed a Health Workforce Plan 2024 . The 2024 workforce plan outlines a number of initiatives that Health New Zealand is undertaking to address these workforce needs.

Health NZ's workforce at a national level has grown significantly since 2020 (as outlined below)

6.6.1 Health NZ workforce changes since 2020

HNZ health workforce has grown significantly since 2020, and particularly over the past year. Comparing trends in Health NZ's employed workforce in full-time equivalents (FTE) with trends in population growth (estimated at 2.4% for the year to March 2024):

- HNZ medical workforce has grown by 3.1% in the year to March 2024, and by 14.1% since March 2020.
- HNZ nursing workforce has grown by 10.9% in the year to March 2024 – nearly 3,000FTE of nurses – and by 21.5% since March 2020. Over the year to March 2024, the number of nurses with Annual Practising Certificates (APCs) in our national nursing workforce has grown by 13%.
- HNZ allied health workforce has grown by 3.5% in the year to March 2024, and by 8.9% since March 2020.
- HNZ midwifery workforce has grown by 11.2% in the year to March 2024 – swinging back from a low following the COVID-19 pandemic – which is reflected in a lower growth rate of 7.1% since March 2020.
- HNZ care and support workforce has grown by 9% in the year to March 2024, and by 31.6% since March 2020.

In the 2024 year there has seen some significant investments in the future of our workforce – including 25 new medical school places, and growth to nurse practitioner training. At the same time, the fruits of investments made between 2020 and 2023 have started to pay off for some of our key allied workforces, with vulnerable professions like oral health therapists and anaesthetic technicians experiencing good growth

Regardless of the workforce progress since 2020, there remain significant pressures at a national level. The following are the projected future needs for the workforce. NDH workforce needs will be part of this picture.

s9(2)(f)(iv), s9(2)(g)(i)

To address the workforce needs HNZ Southern has developed a number of actions that are contained within a Change Management Plan. These actions will also be used to address the NDH workforce requirements.

One of the key things that HNZ does is work with Tertiary Education Commission (TEC) and where applicable local tertiary education institutes over the courses they run and volumes of places that are available to train the necessary health professionals. These approaches to TEC are informed by current and anticipated demand and supply of professionals and includes consideration of changes arising from hospital infrastructure developments.

6.6.2 Data and Digital

Digital infrastructure and digital software solutions are essential to enable the NDH to operate as designed and obtain wider benefits from model of care changes that underpin the numbers of operating theatres, treatment areas, hospital, and other services. The design, procurement and delivery of the digital scope however is not managed by the NDH overarching project nor is it included in the NDH business case. The Digital Project does however closely manage the interdependencies with the overarching NDH project.

In 2021 Cabinet agreed to a s9(2)(b)(ii) for data and digital [GOV-21-MIN-0011 refers] while a series of business cases were developed confirming the scope, benefits and costs associated with the digital investment required to support the NDH.

A detailed business case for Southern Digital Transformation was approved by the Board of the SDHB in March 2022. The business case covered digital infrastructure and digital software solutions for both stages of the NDH (stage 1 outpatients building and stage 2 inpatients building) along with an uplift to the broader Southern Health system (including NDH, Southland and Lakes District hospitals and the rural trust hospitals where appropriate).

In their review of the detailed business case the Capital Investment Committee (CIC) and the Data, Digital and Innovation Committee of the Te Whatu Ora Board recognised and supported technology investment for the NDH however raised affordability concerns and requested a staged approach and adjustments to provide a lower cost option. They also considered the objectives of system reform and noted future transformation of digital software solutions should be led nationally. The scope of the investment was reduced to focus on stage 1 of the NDH only (outpatients building) and included all digital infrastructure required to deliver a contemporary, modern hospital and minimal development of existing digital software solutions to enable effective functioning of the new outpatients building.

s9(2)(b)(ii)

s9(2)(b)(ii) They also noted development of digital infrastructure and digital software solutions required to support stage 2 of the NDH (inpatients building).

A stage 2 digital implementation business case is now under development which will confirm the scope and costs of the digital investment required to support the NDH inpatient building. The business case will be informed by the digital infrastructure which is currently being deployed into the outpatient building and aim to extend this technology and provide a contemporary, integrated infrastructure platform across the NDH campus. The business case will also include digital software solutions aligned with the 10-year Digital Investment Plan.

6.7 Benefits realisation management

Benefits realisation is led by Health NZ's Southern Operational Readiness Team (SORT). The Benefits Realisation Plan was last updated in June 2025. It covers both the design and construction of NDH and the system-wide benefits to be realised from the Change Management Programme.

The benefits associated with the Inpatient Building component of the NDH Programme were outlined earlier in the Economic Case, section 3.4. The benefits owners are outlined in the table below.

Table 308: Project Benefits

NDH Benefit	Owner
Modern, fit-for purpose facilities create	Tony Lloyd (Inpatient Building Project Director) Andrew Holmes (Outpatient Building Project Director) Bridget Dickson (Programme Director, HSS Southern)
Increased NDH capacity, including operating theatres	Tony Lloyd (Inpatient Building Project Director) Craig Ashton (Interim GDO, Southern)
Improved NDH acute service resilience and responsiveness	Tony Lloyd (Inpatient Building Project Director) Bridget Dickson (Programme Director, Southern)
Improved building performance/reduced environmental impact of NDH vs DPH	Tony Lloyd (Inpatient Building Project Director) Andrew Holmes (Outpatients Project Director) Southern's Facilities and Property Team

The benefit owners have agreed to be responsible for achieving the benefits; this agreement is recorded in the Benefits Realisation Plan. Health NZ's SORT will reinstate regular reporting on benefits realisation from 2026 and will provide recommendations to the Benefit Owners about management actions that are necessary to improve the likelihood of benefit being realised

s9(2)(g)(i)

6.8 Health and Safety

Having safe workplaces, for both patients and staff, both during construction and onwards is a priority for Health NZ. During the construction of the NDH facilities critical risks will be monitored and managed. There is a delivery framework in place for managing these risks and clear expectations for infrastructure projects. Specialists AvidPlus have been contracted to observe and report on the practices of CERES (ground preparation and piling) and CPB's construction activity.

6.9 Assurance and post-project arrangements

The project will be subject to the following assurance activities.

Table 31: Assurance and post-project arrangements

Assurance Activity	Purpose	Reporting to	Provider	Timing
Independent Quality Assurance (IQA)	IQA reviews are a central agency assurance requirement for high value, multi-year, high risk or complex projects. These reviews will occur at key project milestones and provide assurance of key process and knowledge areas and of the project's overall progress towards success.	Crown Manager, with a direct copy being provided to other agencies as per monitoring requirements. Engagement managed by the project PMO, under the Project Director	KPMG	Aligned to major project milestones.
Gateway™		Crown Manager	Treasury is the review provider and charges a fee to the Ministry for each review. Review teams are comprised of highly independent reviewers selected and managed by Treasury.	At each of the major control gate points).
Treasury Major Projects monitoring	Meetings as required with Treasury to review the status of the project	Project Director	Treasury	As required.

Assurance Activity	Purpose	Reporting to	Provider	Timing
Probity Advice/audits	Probity advice/audits are required to provide independent assurance that all procurement decision making processes are equitable and comply with prescribed practices and directions.	Project Director	McHale	Aligned to major procurement milestones.
Legal Reviews	Independent legal review and advice in respect to contractual documentation.	Project Director	HNZ's independent legal advisors.	Procurement stage and pre-contract signature.
Technical Peer Reviews	Independent technical peer reviews in during design (including VM), structural engineering (including seismic) and building services, and programme and cost estimates.	Project Director	Independent external technical specialists.	Programme and cost estimate as part of developing the Detailed Business Case. Design and construction stages.
Post Implementation and Benefits Realisation Reviews	A Post Implementation Review will be performed no sooner than six months after the project's closure to assess Benefits Realisation effectiveness and review operational hand-over of the hospital facilities and other project outputs.	Project Director	To be confirmed.	Six months after project closure.

6.9.1 Quality management

KPMG have been engaged to provide Independent Quality Assurance (IQA) throughout the life of the NDH Project. The latest assessment on project financials was completed on 20 December 2023. The key focus was to understand how the interface between the Project Management system (Procore) and the Finance, Procurement, and Information System (Oracle FPIM) currently utilised and how financial management controls is are maintained for the project using these two systems.

The main recommendations were:

a. **System Integration** – Prioritise synchronisation and system integration between Procore and Oracle FPIM to create a single source of truth, presenting real time accurate presentation.

b. **Financial delegation guidelines** – To ensure consistency and compliance on NDH (and across all IIG projects), it is necessary to roll out the Financial Delegations and Project Controls Guideline for all budget approvals and expenditures in both Procore and Oracle FPIM systems.

c. **Cost Reconciliation** – Until such time that the two systems are integrated, to ensure accurate financial monitoring, it is necessary to conduct regular and thorough reconciliations. A bi-monthly alignment review should be conducted at a pre- determined cut-off date to ensure that the OS monthly financial report is consistent with Procore, and that both align with the Oracle FPIM, until such times that the systems are integrated.

6.9.2 Assurance

The project team has established the following assurance processes to plan, review and validate the work of CPB:

- Cost Management: RLB will manage and report on cost matters and advise Health NZ on variation costs and contingency spend
- Programme Management: Woods Harris have been contracted to review the progress of CPB against the agreed contract programme and report to Health NZ
- Risk Management: RCP will monitor and report on the development and reporting from CPB's risk management processes
- Design Management is the responsibility of CPB .
- As the design contracts will remain directly with Health NZ, the design consultants are also contractually obligated to report any instances of CPB activity not in accordance with the agreed design or specifications.
- Health & Safety: AvidPlus have been contracted to observe and report on CPB's health & safety activity.
- Building Information Modelling: IIMBIE have been contracted to provide assurance through the development of the design model and will be retained during construction to assure Health NZ that the ongoing development of the model is being delivered by CPB as per the requirements.
- Building Services Commissioning: Pacific Consultants have been engaged to provide the Independent Commissioning Agent role required to assure Health NZ that the building services commissioning has been completed.

6.9.3 Gateway Reviews

This investment proposal has been assessed as high risk using the Treasury's Risk Profile Assessment (RPA)[7] tool and moderation process. These review stages will be used by the New Dunedin Hospital project as the primary control gates for quality assurance.

Table 32: Gateway

Gate	Scope	Purpose	Status
Gate 0	Strategic assessment	Review of strategic direction of the proposed investment	Complete (June 2016) https://www.tewhatuora.govt.nz/assets/Health-services-and-programmes/Infrastructure-and-Investment/NDH-Gateway-Review-ID-1202-Gateway-0-Strategic-Assessment-June-2016.pdf
Gate 1	Business Justification and Options (*Indicative Business Case)*	How the business requirement can be delivered. Affordability, achievability and value for money established.	*Complete* (June 2017) https://www.tewhatuora.govt.nz/assets/Health-services-and-programmes/Infrastructure-and-Investment/NDH-Gateway-Review-ID-1235-Gateway-1-Business-Justification-and-Options-June-2017-v2.pdf
Gate 2	Delivery Strategy (Detailed Business Case)	The acquisition and delivery strategy are appropriate for the desired business change. Implementation plans are in place.	Complete (June 2020) https://www.tewhatuora.govt.nz/assets/Health-services-and-programmes/Infrastructure-and-Investment/NDH-Gateway-Review-ID-1344-Gateway-2-Delivery-Strategy-Detailed-Business-Case-June-2020.pdf
Assurance Action Plan	Assurance Action Plan	To review Assurance Action plan	Complete (November 2020) https://www.tewhatuora.govt.nz/assets/Health-services-and-programmes/Infrastructure-and-Investment/NDH-Gateway-Review-ID-1344-Gateway-2-Delivery-Strategy-Detailed-Business-Case-June-2020.pdf
Gate 0	Mid-State Gateway Review	Progress review	Complete (December 2021) https://www.tewhatuora.govt.nz/assets/Health-services-and-programmes/Infrastructure-and-Investment/NDH-Gateway-Review-ID-1409-Gateway-0-Mid-Stage-Gateway-Review-December-2021.pdf
Gate 3	Investment Decision (Implementation Business Case)	The project is still required, affordable and achievable. Implementation plans are robust; investment decision is appropriate.	Before a contract is signed with a supplier and funding and resources committed.

[7] https://www.treasury.govt.nz/information-and-services/state-sector-leadership/investment-management-system/investment-planning/risk-profile-assessment

Gate	Scope	Purpose	Status
Gate 4	Readiness for Service	The organisation is ready to make the transition to implementation. Ownership and governance are in place for operation.	Before “Go-Live.”
Targeted Investment Review	Operational Review and Benefits Realisation	Confirm smooth operation, delivery of outputs and achievement of benefits.	After a project’s transition into business.

Specific concerns raised in the Gateway Reviews

s9(2)(ba)(i)

A Targeted Investment Review (TIR) is scheduled for 12 -13 August 2025.

6.9.4 Design Assurance

Design Assurance processes have been established by the IIG Health Facility Planning team. The purpose of this assurance is to monitor and enforce standardisation across public health facilities. Assurance is provided against the Australian Health Facility Guidelines (AusHFGs) and the Health Planning Units (HPUs). There is also consideration given to the process of user engagement, development of Models of Care, Functional Design Briefs and Schedules of Accommodation.

The Project team have engaged with IIG Health Facility Planning and Design Assurance representatives throughout the design process to ensure that the project design meet the requirements.

6.10 Post-project reviews

A post implementation review is planned for the year following the completion of the project to confirm that the new system/facilities are operating as intended and delivering the services proposed in the business case, and to identify any lessons learned from the management of the project/tranche that can be applied to future projects or projects in other agencies.

As required by Cabinet Office Circular CO(19)68, this project will report back to Cabinet within 12 months of the in-service date on the actual level of benefits achieved compared with those outlined in the Cabinet-approved investment.

A Treasury Operations and Benefits Realisation Review will be undertaken at agreed points; the initial review will be timed to inform the Benefits report-back to Cabinet.

[8] https://dpmc.govt.nz/publications/co-19-6-investment-management-and-asset-performance-state-services

6.11 Risk Management

The risk and issues approach for NDH is aligned with the Health NZ Enterprise Risk Management Policy, and the risk management process is based on the international risk standard AS/NZ ISO 31000: 2018.

Figure 5: Risk Management Process

If a potential risk becomes an active problem, it must then be reported as an issue. Escalation is critical to ensuring that issues requiring intervention are actioned promptly.

Figure 6: Risk/Issue Escalation Process

Risks and issues are captured in registers for inclusion in Project Control Group reporting and as an input to regular governance and assurance reports. Registers are maintained and shared for the following areas:

- Design
- Construction
- Furniture, Fixtures & Equipment (FFE)

While separate, the following risks and issues registers are also shared:

- Southern Districts Operational Readiness Programme
- Digital Programme

All registers have been developed in accordance with an overarching NDH Risk Management Plan.

- Identification and implementation of appropriate actions or strategies to reduce, avoid, or mitigate the assigned risks/issues.
- Ensuring timely completion of identified actions by their target dates.
- Ongoing assessment of the likelihood and impact rating for each assigned risk/issues.

- Providing updated information related to the assigned risks/issues for inclusion in the registers.

Designated project leads are required to review and provide update the registers each month. The RCP Project Manager, CPB, lead consultants, the Quantity Surveyor, and representatives from the data transformation and workforce transformation workstreams all attend Project Control Group where key issues and risks are discussed (or new risks identified). The current version of the registers (as of July 2025) is available on request.

Table 33: Top current risks and issues s9(2)(f)(iv)

	Key project risks
1	Community discord with the delay/ changes in scope.
2	Clinical discord with the delay/reduction
3	HNZ restructure and processes affecting timeliness of decisions
4	Delay to construction commencement due to pricing exceeding budget
5	Replacement of Major Subcontractors - no longer suitable or able to complete the works (through liquidation or termination)
6	Programme extensions due to redesign
7	Insufficient supply of Skilled Resources
8	Adverse Weather

7 Annexes

Annex 1: Business Case Confirmation Letter

Annex 2: Investment Logic Map

Annex 3: Capacity of New Dunedin hospital

Annex 4: Assessment of the short-listed options against the investment objectives

Annex 5: Benefits Realisation Plan

Annex 6: Additional financial information

Annex 7 Procurement Evaluation Criteria

Annex 8: Health Workforce Action Plan

Annex 9: Documents supporting this business case

Annex 1: Business Case Confirmation Letter

4 August 2025

Minister of Health
Minister of Finance
Minister for Infrastructure
Minister for Regional Development

Implementation Business Case: New Dunedin Hospital

Health New Zealand | Te Whatu Ora is proposing to commence construction of the New Dunedin Hospital Inpatient Building with CPB Contractors Ltd. This proposal is part of the approved Infrastructure Investment Plan signed off by Cabinet in April 2025.

This Implementation Business Case outlines the contractual arrangements and planning for delivery.

I confirm that:

1. I have been actively involved in the development of the preferred option and the attached investment proposal.
2. I accept the strategic aims and investment objectives of the investment proposal, and its functional content, size and services.
3. the indicative cost estimates of the proposal are sound and based on best available information, given the stage of business case development; and
4. suitable contingency arrangements are in place to address current or unforeseen affordability pressures.

This letter fulfils the requirements of the current Better Business Cases guidance. Should either these requirements or the key assumptions on which this case is based change significantly, revalidation of this letter of support will be sought.

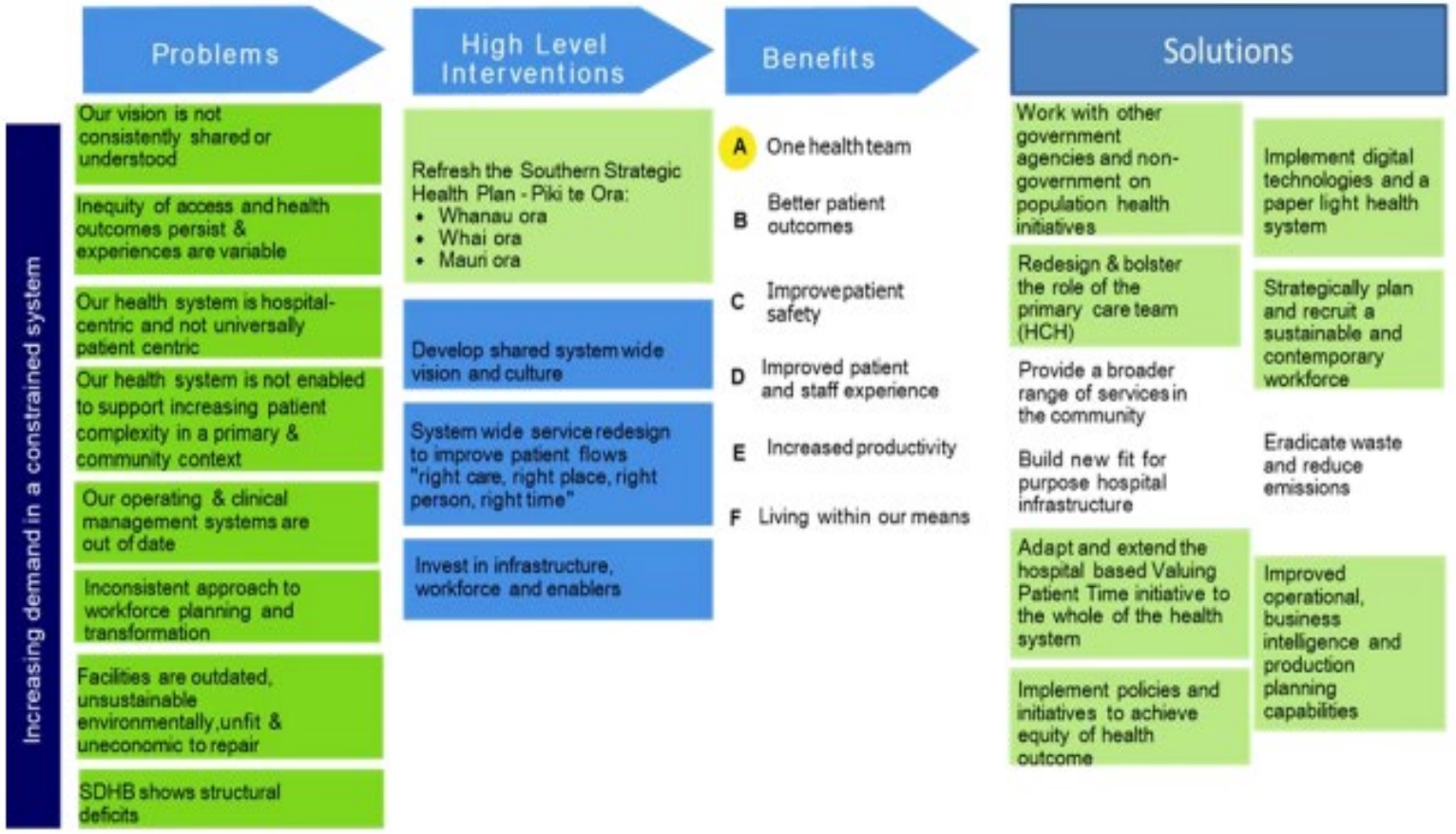
Yours sincerely

s9(2)(a)

Evan Davies

Crown Manager, Health NZ

Annex 2: Investment Logic Map



Annex 3: Capacity of New Dunedin hospital

Overnight beds (inc. 23-hour)

Ward	Dunedin Hospital Current Built Capacity 2024	Dunedin Hospital Resourced Beds Snapshot 2024	Final Detailed Business Case	New Point of Care Modelling 2024 2037/38 planning horizon	New Dunedin Hospital Operational 2031	New Dunedin Hospital Future proof capacity **Stage 2**[1] Operational 2037/38	Capacity change from current Dunedin Hospital to NDH Including new models of care information
Maternity	31	17	24	21	20 *(plus 3 cold shell)*	23 *(incl. 3 primary birthing post-natal beds)*	Maternity bed numbers align with standardised national modelling which notes declining birth rate.
Neonatal	18	16	22	15	22	22	Reflects increased severity of health issues.
Self-care, transitional beds	7	-	12	0	12	12	Increase allows parents to stay in proximity.
Paediatric	19	16	16	11	16	16	Aligns with internationally consistent changes in model of care to deliver more care in ambulatory settings.
Medical / Surgical (includes Medical HDU)	263 *(includes 10 CCU beds, 16 MAPU)*	231	235[9]	295 *(includes 264 med/surg, 22 MAPU and 9 CCU)*	237 *(plus 26 cold shell)*	263	Future proofing Medical /Surgical includes 26 additional beds. *Noting due to new models of care, on opening there is also a 23-hour Unit (20 beds) and Day Medical (16 beds), which have a higher occupancy per day compared to an overnight bed.

[9] During the reset it was identified 11 Med Surg beds had been double counted. 246 beds were incorrectly listed in the NDH Detailed Business Case, corrected here.

Ward	Dunedin Hospital Current Built Capacity 2024	Dunedin Hospital Resourced Beds Snapshot 2024	Final Detailed Business Case	New Point of Care Modelling 2024 2037/38 planning horizon	New Dunedin Hospital Operational 2031	New Dunedin Hospital Future proof capacity Stage 2[1] Operational 2037/38	Capacity change from current Dunedin Hospital to NDH Including new models of care information
Mental health services of older people	12	9	21	8	8	8	The provision of 8 MHSOP beds in NDH reflects the updated modelling and a re-defined model of care for older persons' mental health. This model places greater emphasis on community-based care for long-term patients and focuses inpatient services at the New Dunedin Hospital (NDH) on acute mental health needs.
Rehabilitation	24	24	40	20	16 *(plus 4 cold shell)*	20	Rehabilitation bed numbers are aligned to standardised national modelling and enhanced care in the community including 'hospital in the home.'
Intensive care, HDU surgical	22	16	40 *(incl. 10 cold shell)*	17 *(includes 4 HDU beds)*	20 *(plus 10 cold shell plus 10 fitted out as interim workspace)*	30 *(plus 10 fitted out as interim workspace)*	NDH will have 20 Intensive Care Unit (ICU) and High Dependency Unit (HDU) beds on opening, with investment in fitting out additional spaces allowing this capacity to increase to 40 ICU and HDU beds over time. The bed spaces earmarked for future fit out have been informed by the modelling and current thinking about models of care.

Ward	Dunedin Hospital Current Built Capacity 2024	Dunedin Hospital Resourced Beds Snapshot 2024	Final Detailed Business Case	New Point of Care Modelling 2024 2037/38 planning horizon	New Dunedin Hospital Operational 2031	New Dunedin Hospital Future proof capacity Stage 21 Operational 2037/38	Capacity change from current Dunedin Hospital to NDH Including new models of care information
Inpatient Beds	**396**	**329**	**410** ***(incl. 10 cold shell)***	**387**	**351** *(plus 43 beds shell plus 10 ICU as interim workspace)*	**394** *(plus 10 ICU as interim workspace)*	
New MoC 23-hour unit (same day beds)	0[10]	0	20	11	20	20	
Total Overnight Inpatient Beds	**396**	**329**	**430** ***(incl. 10 cold shell)***	**398**	**371** *(plus 43 beds shell plus 10 ICU as interim workspace)*	**424**	

[10] The 23-hour unit is a new model of care that will seek to get greater efficiency from operating theatres and inpatient beds

Operating Theatre Requirements (Inpatient and Outpatient)

Operating theatres	Dunedin Hospital Current Built Capacity 2024	Final Detailed Business Case	New Point of Care Modelling 2024 2037/38 planning horizon	New Dunedin Hospital Operational 2031	New Dunedin Hospital Future proof capacity **Stage 2**[1] Operational 2037/38	Capacity change from current Dunedin Hospital to NDH Including new models of care information
Acute and elective	10	15 *(incl. 4 cold shell)* ***13 under 2022 design reset***	12 *(11.9 rounded up)*	12 *(plus 2 cold shell)*	12 *(incl. 1 hybrid)*	Acute, elective and same day operating theatres are standardised in their design to enable them to be used flexibly to meet the demand over time in acute and elective procedures.
Same day	2 *(plus 1 outplaced leased theatre at Filleul St - eyes)*	5	4 *(3.8 rounded up)*	4 *(maintain 2-day surgery theatres in OB)*	4	
DSA / angiography	1	2	1 *(0.5 rounded up)*	2 *(incl. 1 hybrid)*	2 *(incl. 1 hybrid)*	Growth in interventional radiology procedures predicted as there is a move away from more invasive treatments.
Cardiac catheter laboratory	1	2	2 *(1.4 rounded up)*	2	2	Growth in interventional cardiology procedures predicted as there is a move away from more invasive treatments.
Endoscopy rooms	3	4	2 *(1.9 rounded up)*	2	4	The number of endoscopy rooms delivered in 2031 aligns with the standardised national modelling. Future proofing to align with future demand and workforce planning.
Total	**17 (+ 1)**	**28** *(incl. 4 cold shell)*	**21** *(rounded up; 19.5 without rounding)*	**22** *(plus 1x hybrid & 1x OT shell)*	**24**	

Outpatient

Outpatient	Dunedin Hospital Current Built Capacity 2024	Final Detailed Business Case 2021	New National Point of Care Modelling 2024 2037/38 planning horizon	New Dunedin Hospital Operational **2031**	New Dunedin Hospital Future-proofed capacity (as per demand)	Capacity change from current Dunedin Hospital to NDH Including new models of care information
Clinic consult rooms	n/a	64	76 total *modelled at sub-speciality level*	64	64	In the current hospital Outpatient activity occurs in a range of spaces incl. dedicated outpatient's clinic rooms and office. The new Outpatients building will encompass all clinics etc in one building.
Specialty clinic rooms	n/a	20		20	20	
Procedure rooms	1	4		4	4	
Medical physiology labs	24	29		26	26	
Transit care	0	12	Not modelled	12	12	Not modelled as currently do not have transit care unit in Dunedin Hospital.
TOTAL:	**Refer Note**	**129**	**76**	**126**	**126**	

Note: In terms of current capacity outpatient activity currently occurs in a variety of spaces including dedicated outpatient clinic rooms plus offices.

Same day and ambulatory rooms

Same day/bed equiv	Dunedin Hospital Current Capacity 2024	Final Detailed Business Case 2021	New National Point of Care Modelling 2024 2037/38 planning horizon	New Dunedin Hospital Operational 2031	New Dunedin Hospital Future-proofed capacity (as per demand)	Capacity change from current Dunedin Hospital to NDH Including new models of care information
Acute dialysis unit	10	8 *(4 under 2022 design reset)*	TBC	4 *4 acute dialysis beds with additional capacity (8x) for dialysis function in medical HDU*	4	Dunedin Hospital delivers acute dialysis, in-centre and renal home training services. The New Dunedin Hospital is scoped to provide acute dialysis services only. In- centre and renal home training services will be delivered as part of a wider clinical service campus plan.
Day medical*	8	16	10	16	16	Increase supports enhanced day stay model of care for medical infusion patients.
Birthing rooms	7	10 *(9 under 2022 design reset)*	5	6 *(5 rooms for secondary birthing, 1 for Te Puna Aroha plus 3 future-proofed spaces for primary)*	9 *(5 rooms for secondary birthing, 3 for primary, 1 for Te Puna, Aroha)*	Birthing rooms are aligned to standardised national modelling and additional room for supporting families who are experiencing baby loss (Te Puna Aroha). Future proofing to include midwife led birthing unit (also known as primary birthing unit).
Maternity assessment unit	4	7	1	7	7	Additional maternity assessment unit capacity supports enhanced same day model of care.
Paediatric assessment unit	5	4	2	4	4	Seven child dedicated same- day spaces in Dunedin Hospital. Eight in NDH evenly split across Inpatient and Outpatient Building.
Paediatric day unit	2	4		4	4	
Sub-total same day & ambulatory (exc. ED)	**36**	**49**	**18** *(acute dialysis TBC)*	**41**	**44**	

Same day/bed equiv	**Dunedin Hospital Current Capacity 2024**	**Final Detailed Business Case 2021**	**New National Point of Care Modelling 2024** 2037/38 planning horizon	**New Dunedin Hospital** Operational **2031**	**New Dunedin Hospital** Future-proofed capacity (as per demand)	**Capacity change from current Dunedin Hospital to NDH** Including new models of care information
ED bays (inc. short stay)	37	53	58	53	53	New Dunedin Hospital has a significant increase in ED bays.
Emergency psychiatric	5	5	Included in ED	5	5	

Imaging

Modality	Dunedin Hospital Current Capacity 2024	Final Detailed Business Case 2021	New National Point of Care Modelling 2024 2037/38 planning horizon	New Dunedin Hospital Operational **2031**	New Dunedin Hospital Future-proofed capacity (as per demand)	Capacity change from current Dunedin Hospital to NDH Including new models of care information
MRI	2	3	2	2 *(plus 1 future- proofed space in OB)*	3	2031 MRI capacity aligns with current Dunedin Hospital capacity.
CT	2*	3 *(4 incl. 1 cold shell under 2022 design reset)*	4	2 *(plus 1 future- proofed space in OB and 4th CT used as interim SPECT CT)*	4	2031 CT capacity aligns with current Dunedin Hospital capacity.
Ultrasound	4	6	4	6	6	Ultrasound delivery has been under delivered in Southern due to longer term workforce challenges. Workforce growing and anticipate will be able to meet demand of six by 2031.
Fluoroscopy	1	1	1	1	1	No change.
OPG/Cone Beam CT	0	1	Not modelled	0	1	Not modelled as currently do not have OPG/Cone Beam CT in Dunedin Hospital.
General x-ray	6	8	10	8	8	New Dunedin Hospital x-ray provision aligned with DBC and two more than current. X- rays can also be delivered routinely in community and urgent care locations closer to home.
SPECT CT	1	1	1	1 *(interim location in CT, SPECT CT permanent location future proofed space)*	1	

Modality	**Dunedin Hospital Current Capacity 2024**	**Final Detailed Business Case 2021**	**New National Point of Care Modelling 2024** 2037/38 planning horizon	**New Dunedin Hospital** Operational **2031**	**New Dunedin Hospital** Future-proofed capacity (as per demand)	**Capacity change from current Dunedin Hospital to NDH** Including new models of care information
DEXA	1	1	Not modelled	0 *(plus 1 cold shell)*	1	Not modelled as separate modality in standardised national modelling and included in general x-ray volumes.
PET CT	0	1	Not modelled	0 *(plus 1 cold shell)*	1	Not modelled as currently do not have PET CT in Dunedin Hospital (or any public hospitals in NZ currently).
TOTAL:	**17**	**25** *(plus 1 shell)*	**22**	**20** *(plus 6 shell)*	**26**	

*Note: A third CT scanner is primarily used as a treatment planning scanner for Southern Blood & Cancer which is out of scope for NDH project.

Annex 4: Assessment of the short-listed options against the investment objectives

Investment Objectives	Status Quo Do nothing	Option 1 Single Building (Cadbury's site)	Option 2 Two Building (Cadbury's site)	Option 3 Single building (Wilson's site),	Option 4 Single building (St Andrews Steet)	Option 5 Inpatient Building (Cadbury's block) Outpatient (Wilson's block)
Create the ability to adapt through responsive infrastructure and capability that supports disruptive health system change						
Optimise use of total health system resources		Significant expenditure taken to build Outpatients Building would be lost	Significant expenditure taken to build Outpatients Building would be lost	Unclear if physically possible to expand building that is being currently built. Highly disruptive to hospital care .. Existing site works on inpatient building would be wasted expenditure	Significant expenditure taken to build Outpatients Building would be lost	Best value for money
Reduce non-value-added time by 80 per cent to create a seamless patient journey						
Improve the patient and staff experience						
Reduce the risk of harm to acceptable standards						

Annex 5: Benefits Realisation Plan

The Benefits Realisation Plan was refreshed in June 2025 and its measures, timeframes, risk and dependencies, and links to Health Targets for each benefit is outlined below:

New Dunedin Hospital-specific Benefit Profiles

Benefit #1	**Modern, fit-for purpose facilities created**									
Benefit Owner(s)	**Tony Lloyd (NDH Inpatient Building Director) & Bridget Dickson (Programme Director, Southern)**									
Description	**Key measures**	**Targets**	**Baseline**	**Linked workstreams**	**Realisation date(s)**	**How reported?**	**How often?**	**Key risks and dependencies**	**Link to CSFs, IOs and ILM**	**Link to Health Targets**
Southern requires a hospital in Dunedin able to support acute and elective services with appropriate physical infrastructure, to support modern flexible models of care, greater accessibility, and standardisation. The hospital will be built to modern building codes and offers considerable resilience including IL4 for critical areas.	1.1 Facility built to appropriate clinical standards	Fully clinically compliant facilities on go live	Practical Completion (October 2030)	• NDH design and build programme • NDH design peer reviews	• OB Go live (October 2026) • IB Commissioned (2031)	Southern's Performance and Accountability reporting	s9(2)(f)(iv)	**Key Risks** • Commissioning & Performance Testing requirements) • NDH Asset Management Plan **Dependencies** • Digital Hospital Programme • NDH models of care/efficiency programmes (as part of BAU) • Digital Programme • Site-wide services programme	**Investment Objectives** – 3, 4, 5 **Critical Success Factors** • Meets business needs • Strategic fit • Delivers perceived value • Relative affordability • Achievable **ILM Benefits** • One Health Team • Better Patient Outcomes • Improve Patient Safety • Improve Patient and Staff Experience • Increased Productivity	• Faster cancer treatment • Shorter stays in emergency departments • Shorter wait times for first specialist assessment • Shorter wait times for elective treatment
	1.2 Fewer patient harm events	Zero falls with serious harm and year on year reduction in other patient harm events	FY 2026/27	• Falls/risk assessment • Nurse call • CCDM Programme • Digital Hospital Programme	• IB Commissioned (2031)	Southern's Performance and Accountability reporting				
	1.3 Improved patient and staff satisfaction rates	Year on year improvement following OB and IB opening	FY 2026/27	• NDH Project • Model of care enhancement projects • II&G build programme • HNZ Recruitment and Retention programmes	• IB Commissioned (2031)	DPH/NDH Staff and patient satisfaction questionnaires				
	1.4 Services to support whānau-based care delivered	Year on year improvement in reported patient satisfaction rates	FY 2026/27	• Mana whenua engagement (MoU) • Pae Ora (Health Futures) Principles delivery programme • Māori Models of Care programme	• OB Go live (October 2026)	DPH/NDH Staff and patient satisfaction questionnaires				
	1.5 Improved accessibility in NDH vs DPH	Fully accessibility compliant facilities	FY 2026/27	• Embedding Te Tiriti, Pae Ora & Quintuple Aims for Healthcare • NDH accessibility assessments (design)	• OB Go live (October 2026) • IB Commissioned (2031)	Independent accessibility assessment				

New Dunedin Hospital-specific Benefit Profiles

Benefit #2	Increased NDH capacity									
Benefit Owner(s)	**Tony Lloyd (NDH Inpatient Building Director) and Craig Ashton (Interim GDO, Southern)**									
Description	**Key measures**	**Targets**	**Baseline**	**Linked workstreams**	**Realisation date(s)**	**How reported?**	**How often?**	**Key risks and dependencies**	**Link to CSFs, IOs and ILM**	**Link to Health Targets**
The NDH will overcome many of the current DPH's physical capacity constraints, including Operating Theatres. The IB has capacity for 371 overnight inpatient beds on opening in 2031, with future proofed capacity for 424 beds. Across NDH, it will have capacity for 22 theatres and procedure rooms in 2031, with future proofed capacity for 24 (subject to demand). Imaging modalities will see up to 20 being operational in 2031, with future proofed capacity (as per demand) up to 26.	2.1 Better reported access to ED, ICU/HDU and recovery spaces vs DPH	Year on year improvement following OB and IB opening	FY 2026/27	• NDH Project (design and build, including engineering and lift provisions) • Production planning	• OB Go live (October 2026) • IB Commissioned (2031)	• Statement of Performance Expectations (HNZ) • Regional/national performance reporting	s9(2)(f)(iv)	**Key Risks** • Theatre Capacity • FF&E Current State Assessment • Lift Modelling and Capacity • FF&E Budget Planning Considerations **Dependencies** • NDH Design and Build Programme • HNZ organisational structure roll-out	**Investment Objectives** – 1, 2, 3, 4 **Critical Success Factors** • Meets business needs • Strategic fit • Delivers perceived value • Achievable **ILM Benefits** • Better Patient Outcomes • Improve Patient and Staff Experience • Increased Productivity • Living Within Our Means	• Faster cancer treatment • Shorter stays in emergency departments • Shorter wait times for first specialist assessment • Shorter wait times for elective treatment
	2.2. Increased diagnostic provision vs DPH	Year on year reduction in NDH diagnostic wait times	FY 2026/27	• NDH Project (design and build) • Workforce modelling (ensuring appropriate staffing)	• OB Go live (October 2026) • IB Commissioned (2031)	• Statement of Performance Expectations (HNZ) • Regional/national performance reporting				
	2.3 Increased theatre productivity	Year on year improvement from OB opening	FY 2026/27	• OB operating principles • Digital hospital programme • NDH Project (design of appropriate theatres)	• Post OB occupancy (>October 2026) • Post IB occupancy (>2031)	• Statement of Performance Expectations (HNZ) • Regional/national performance reporting				
	2.4. Day surgery productivity (interim and final state)	Year on year reduction in wait times to surgery to accepted levels	FY 2026/27	• NDH Project (design and build) • Production planning • Digital hospital programme	• Post OB occupancy (>October 2026)	• Statement of Performance Expectations (HNZ) • Regional/national performance reporting				

New Dunedin Hospital-specific Benefit Profiles

Benefit #3	Improved NDH acute service resilience and responsiveness									
Benefit Owner(s)	Tony Lloyd (NDH Inpatient Building Director) and Bridget Dickson (Programme Director, Southern)									
Description	**Key measures**	**Targets**	**Baseline**	**Linked workstreams**	**Realisation dates**	**How reported?**	**How often?**	**Key risks and dependencies**	**Link to CSFs, IOs and ILM**	**Link to Health Targets**
A new hospital with digital infrastructure and systems brings benefit in the form of greater resilience to the local health system, allowing the above benefits to be realised. Resilience means many of the risks inherent in the current hospital buildings and through the short-to-medium term during the base case 'do minimum' option would be avoided. There would also be better connectivity, including digital connectivity, with the wider Regional health system.	3.1 Optimised clean and dirty flow separation maintained	Zero instances of clean/dirty contamination reported (rolling average)	FY 2026/27	• NDH Project (design and build) • NDH FiT Group engagement process	• Post-OB occupancy (>2027) • Post-IB occupancy (>2031)	• IPC survey/ reporting (ongoing) • Health and safety reporting • NDH design peer review	s9(2)(f)(iv)	**Key Risks** • Building design flexibility and function • Impacts of Pandemics on Future Planning • Shell Spaces • Uncertainty between current and future states **Dependencies** • HNZ Pandemic Planning directions • NDH governors' expansion plan • Digital Programme	**Investment Objectives** -- 1, 2, 3 and 5 **Critical Success Factors** – • Meets business needs • Strategic fit • Achievable **ILM Benefits** • One Health Team • Better Patient Outcomes • Improve Patient Safety • Increased Productivity • Living Within Our Means	• Faster cancer treatment • Shorter stays in emergency departments • Shorter wait times for first specialist assessment • Shorter wait times for elective treatment • Improved Immunisation rates
	3.2 A facility better optimised to achieve patient flow	Stay below patient flow targets/ measures	FY 2026/27	• Production planning • Digital hospital programme • Generalism • CCDM	• Post-IB occupancy (>2031)	• Statement of Performance Expectations (HNZ) • Regional/national performance reporting				
	3.3 NDH Pandemic response measures implemented	Pandemic response measures operational from IB opening	FY 2026/27	• NDH Project (design and build) • Pandemic readiness – operations/continuity plan	• Post-IB occupancy (>2031)	• Regional/national performance reporting				

New Dunedin Hospital-specific Benefit Profiles

Benefit #4	Outpatient Building facilitating outpatients as a unified service+
Benefit Owner(s)	Bridget Dickson, Programme Director (Southern)

Description	Key meas-ures	Targets	Baseline++	Linked workstreams	Realisation date(s)	How reported?	How often?	Key risks and dependencies	Link to CSFs, IOs and ILM	Link to Health Targets
The creation of the Outpatient Building will help facilitate Southern's operation of outpatients as a unified service, underpinned by digital technology.	4.1 IL3 OB built	OB built to programme (July 2026)	FY 2025/26	• NDH Project (design and build)	• From OB Go Live (October 2026)	• OB commissioning report on opening	s9(2)(f)(iv)	**Key Risks** • Migration and commissioning of the Outpatients Building • Changes in future models of care **Dependencies** • Development of OB Transition Programme • Change Management Programme (NDH Dependency) • Digital Programme	**Investment Objectives** – 1, 2, 3, 4 and 5 **Critical Success Factors** • Meets business needs • Strategic fit • Delivers perceived value • Relative affordability • Achievable **ILM Benefits** • One Health Team • Better Patient Outcomes • Improve Patient and Staff Experience • Increased Productivity	• Shorter wait times for elective treatment; • Shorter wait times for first specialist appointments; • Faster cancer treatment.
	4.2 Increased OP clinic capacity vs DPH	Year on year increase in OP clinics appointments in held in OB	FY 2025/26	• NDH Project (design and build) • OB Clinic Utilisation project • Migration programme • NDH Project (design and build)	• Post OB occupancy (>October 2026) *– NB: service change management will occur earlier*	• H&SS Southern's Management Reporting (District and Regional)				
	4.3 Increased ratio of telehealth events to outpatient attendances	Year on year improvements in uptake (>2027)	FY 2025/26	• Telehealth programme • Digital hospital programme	• Post OB occupancy (>October 2026)	• H&SS Southern's Management Reporting (District and Regional)				

+ Specific benefits associated with the OB Transition Programme are being developed separately, which align back to the NDH Benefits Realisation Plan (and the NDH DBC's Investment Logic Map)

++ Based on timing of Health NZ harmonised datasets being available

New Dunedin Hospital-specific Benefit Profiles

s9(2)(b)(ii)

s9(2)(b)(ii)

s9(2)(b)(ii)

s9(2)(b)(ii)

s9(2)(b)(ii)

Personnel requirements for the new Inpatient Building

s9(2)(f)(iv)

s9(2)(f)(iv)

Annex 7: Procurement Evaluation Criteria

Non weighted evaluation criteria

The appointment of the Main Contractor Early Contractor Engagement was made on 4 October 2021. The following Non-weighted Evaluation Criteria were used at the time. These were reviewed and scored by subject matter expert advisors, before being considered and moderated by the Evaluation Panel.

Non-weighted Evaluation Criteria	Description	Reviewer
Legal structure and financial viability	Whether the Respondent(s') legal structure meets the expectation of the Ministry, and whether each entity holds an adequate financial position for the size of the Outpatient Building Project.	PricewaterhouseCoopers (PwC)
Due diligence disclosure statement	Whether any disclosed matters, if upheld or came to fruition, are likely to impact the Ministry and/or the NDH Project.	PwC
Contract and contract works insurance policy	Whether a Respondent's position on contractual matters and insurance policy wording departs from the Ministry's position and whether such departure is agreeable by the Ministry.	Chapman Tripp and Marsh Insurance
Health, safety and wellbeing	Whether a Respondent's health, safety and wellbeing culture, practices, and process meet the expectation of the Ministry.	Avid Plus
Example management plans	Whether a Respondent's quality of planning and documentation meet the expectation of the Ministry	RCP

Weighted evaluation criteria

Main Contractor Proposals were evaluated by the Evaluation Panel, with technical advice from RLB, Woods Harris and Southern DHB, against the following Weighted Evaluation Criteria: The Main Contractor RFP contained three preconditions related to prior experience, legal structure, and agreement to the NDH Health & Safety Charter.

	Weighted Evaluation Criteria	Weight
1	Broader outcomes and Construction Sector Accord	5%
2	Organisation track record and experience	10%
3	Key subcontractor relationships	15%
4	Capability and capacity	18%
5	Programme	15%
6	Methodology	12%
7	Weighted non-price criteria subtotal	**75%**
8	Price	25%
9	Weighted criteria total	**100%**

Annex 8: Health Workforce Action Plan

The following are excerpts from the Health Workforce Pan 2024 that outline five workforce priorities to make sufficient progress towards workforce sustainability.

Priority One Actions

Action	What we'll do
RIGHT-SIZE TRAINING VOLUMES	
1.1 Secure educational training capacity	Secure 100 new training places for students in tertiary training programmes where we need growth – including for sonography, radiation therapy, oral health therapy and podiatry.
1.2 Boost Health NZ's placement capacity	Expand and improve Health NZ capacity for allied and specialist nursing placements, including for anaesthetic technicians, oral health therapists, medical imaging technologists, podiatrists, cardiac sonography and cancer nursing. Expand Health NZ's capacity for medical training to meet recent increases to medical school capacity and planned new medical school capacity.
1.3 Match tertiary training capacity to future need	Review all health system training volumes for which we have modelling against expected workforce demand by 2035; and outline required tertiary training growth to meet demand.
1.4 Streamline tertiary training programmes	Re-design tertiary training pathways (working with the tertiary sector) to align training times to global norms, introduce more flexible pathways, and address student attraction and attrition.
1.5 Improve use of simulation	Establish a national, interprofessional simulation training service for Health NZ teams, to support and deliver consistent, high-quality simulation-based learning.
REDUCE STUDENT ATTRITION	
1.6 Improve student placements	Launch a new system for student placements to coordinate capacity nationwide and better allow students to indicate placement preferences (including where and when they are placed).
1.7 Alleviate financial pressure in training	Establish a fund for students suffering significant financial hardship while in their final years of health training to support them to complete – targeting workforces with significant current or anticipated shortages.
IMPROVE SYSTEMS AND PLANNING	
1.8 Continue improving reimbursements	Where we are contractually required to fund practising fees, move to pay these directly; and reduce our average processing times for large reimbursements.
1.9 Improve national workforce planning	Improve workforce planning, including by reviewing our models of current and future supply, and enabling scenario- and demand-based modelling of workforce supply. Develop a national map and adopt national planning of medical training volumes, so we can align future increases in training numbers to specialties where need is greatest.

Priority Two Actions

Action	What we'll do
CHANGE HOW WE DELIVER CARE	
2.1 Adapt specialist models of care	Review models of care and service delivery models across priority specialist areas, including dermatology and radiology, and get started implementing improved models. Add 50FTE of additional SMO capacity to services that need it, to support innovation and sustainability, and to drive improved specialist models of care. Support growth in specialist nursing workforces.
IMPROVE OUR PEOPLE'S EXPERIENCE OF WORK	
2.2 Establish consistent benefits of employment	Review all the services we provide Health NZ workers on our sites – including childcare and rural accommodation.
2.3 Improve support for progression	Expand development opportunities for Health NZ workers in areas with less clear pathways today, including for orderlies, addiction roles and support roles.
2.4 Allow for more flexible rosters	Get digital rostering tools in place across for more Health NZ frontline staff, to improve productivity and workforce deployment – both for our staff and our system. Adopt consistent rostering approaches for Health NZ staff who need flexibility, to make flexibility more accessible for our staff.
2.5 Launch flagship services to keep staff well at work	Launch our Kaimahi Hauora Service for staff wellbeing, and the Resident Doctors' Support Service, to support Health NZ workers to deliver safe, exceptional care.
2.6 Keep our people safe at work	Deliver a protective security programme to keep frontline Health NZ staff safe, including delivering the ED Security Improvement Programme funded through Budget 2024.
STRENGTHEN OUR CULTURE AND LEADERSHIP	
2.7 Strengthen clinical and service leadership	Invest in Health NZ's clinical and service leadership to ensure compassionate, effective leadership practices across our services. Continue strengthening Health NZ's clinical leadership structures, including clinical networks, our clinical senate, and clinical advisory groups.
2.8 Make an improved national culture real	Roll out a national culture programme for Health NZ services to bring the NZ Health Charter to life, focused on how we work – with an evidence-based approach to how we make good decisions, work interprofessionally, and keep our staff psychologically and physically well.

Priority Three Actions

Action	What we'll do
GROW OUR FOUNDATION	
3.1 Expand our foundational workforces	Fund earn-as-you-learn training for 120 kaiāwhina per year to train into enrolled nursing or allied health roles. Fund 200 health workers in entry level roles to obtain Level 3 or 4 health qualifications, including Level 4 training for 90 additional consumer, peer support and lived experience (CPLSE) workers annually. Support a wider range of roles to contribute to primary and community care, including extended care paramedics and physician assistants.
3.2 Establish and grow assistant roles	Establish new allied assistant roles with associated models of care. Work with tertiary education providers and the New Zealand Psychologists Board to establish a training programme for at least 20 associate psychologists per year.
3.3 Attract students to health careers	Launch a national attraction campaign to get students interested in health careers.
3.4 Improve graduate transitions	Establish 20 additional New Entry to Practice (NEP) roles for allied professionals, with a focus on innovative care settings. Expand early career supports for mental health nurses transitioning out of NESP training.
ADDRESS PRIMARY AND COMMUNITY SHORTAGES	
3.5 Grow our GP and community medical workforce	Establish a new primary care pathway for House Officers, offering 50% of runs in community settings. Move to publicly employ public health medicine and rural hospital medicine registrars to smooth their employment pathways and reduce attrition. Continue to target 300 GP trainees into the GP Education Programme (GPEP) as an annual intake. Support the development of new medical school clinical placements in line with business case processes. Support community initiatives targeting local workforce sustainability in hard-to-staff areas.
3.6 Bolster maternity care	Launch a new model of midwifery education, using an urban satellite training model. Develop a midwifery assistant role to support midwifery capacity.
PREPARE FOR FUTURE CHANGE	
3.7 Extend scopes through training	Continue to support nurse practitioner training, and work to revise our approach to nurse practitioner training with clinicians, providers of training and regulators for 2026.

Priority Four Actions

Action	What we'll do
BUILD CAPACITY IN VULNERABLE SERVICES	
4.1 Focus international recruitment	Target international recruitment investment at our most severe workforce demands, and areas of insufficient domestic supply.
4.2 Expand medical training in vulnerable specialties	Offer employment to all New Zealand-trained new medical graduates from 2026, including international students who want to work in New Zealand. Establish a pool of funding for small, vulnerable specialties to support training sustainability – including dermatology, rheumatology and gynaecological oncology. Add 5 radiology and 6 dental advanced training roles. Establish new House Officer runs in high-need specialties such as psychiatry. Grow to 50 psychiatry training roles in Health NZ services from 2025 onwards.
4.3 Grow mental health and addiction capacity	Establish 10 additional Health NZ clinical psychology intern roles in 2025; and 10 more in both 2026 and 2027 (for 30 total in 2027). Encourage universities to increase post-graduate clinical psychological training capacity by 10 students in 2025; and a further 10 students in both 2026 and 2027 (for 30 total in 2027). Support an additional 110 specialist nurses, occupational therapists and social workers to undertake NESP training. Expand on NESP training opportunities for vulnerable sub-specialties, including forensics, ID and addiction. Update the clinical framework and training resources which support health professionals working with coexisting substance use and mental health problems. Improve support for community providers to recruit support workers; and promote and support connections with the primary and community sector by funding training opportunities for those in support roles.
PREPARE FOR FUTURE GROWTH	
4.4 Establish advanced practice roles	Establish new advanced scope practice pathways to make the most of allied and nursing capabilities, starting with physiotherapy and radiation therapy. Establish mental health peer support specialist roles in eight emergency departments.
4.5 Create private training capacity	Reach agreement with our major private providers of public health services (e.g. private hospitals delivering public surgical lists) to allow training in private settings, with consistent terms.
EXPAND OPPORTUNITIES FOR EMPLOYMENT	
4.6 Make better use of overseas-trained staff	Continue to support 10 NZREX doctors per year through each of the Primary Care Pathway and NZREX Bridging Programme.
4.7 Keep our people while training overseas	Make advanced employment offers for Health NZ health workers going overseas for vocational training, where we know we will have national need by the time they return.

Priority Five Actions

Action	What we'll do
ENSURE CULTURALLY SAFE AND EFFECTIVE SERVICES	
5.1 Adopt common cultural safety expectations	Develop a suite of common expectations for culturally safe practice – for ethnic, gender, disability and LGBTQIA+ diversity – and work with tertiary education providers and regulators to adopt them across our whole health workforce.
5.2 Review recruitment processes for inclusivity	Review our recruitment processes for Health NZ workers with a range of diverse staff, and redesign them with a view to attracting exceptional, diverse talent.
STRENGTHEN OUR MĀORI WORKFORCE	
5.3 Invest appropriately in Māori-focused programmes	Continue review and funding of effective initiatives to increase recruitment and retention of Māori workforce that directly impact on improved access to care and outcomes for high need groups.
5.4 Grow mātauranga Māori specialists	Develop new mātauranga Māori roles in key workforces where we have evidence that intervention improves access and health outcomes.
STRENGTHEN OUR PACIFIC WORKFORCE	
5.5 Invest appropriately in Pacific-focused programmes	Continue review and funding of effective interventions that grow Pacific health workforce that directly impact on improved access to care and outcomes for high need groups.
STRENGTHEN OUR DISABLED WORKFORCE	
5.6 Open pathways for disabled people	Work with tertiary education providers to create explicit, inclusive training pathways for disabled people into key allied professions.
BETTER SUPPORT RURAL COMMUNITIES	
5.7 Establish rural training hubs	Establish three rural training hubs at sites across New Zealand, employing long-term rural placements for students.
5.8 Support workforce into rural settings	Develop a Supported Entry to Rural Practice programme to acclimate professionals across the health system to rural settings when they first start work rurally.
5.9 Increase rural hospital medical specialist training and support	Grow the number of rural hospital medical specialists we train across the system, and improve support available to trainees to bolster retention in rural settings.

Annex 9: Documents supporting this business case

The Project Director attests that:

- The planning and control documents summarised and referenced in this Implementation Business Case (listed below) are in place or substantially under development and will be the basis for management of the Inpatient Buildings construction
- The project management structures, plans and processes are in place to ensure successful delivery.

These documents are available to decision-makers, Monitoring Agencies, Central Agencies and Functional Leads for review.

#	Title	Date	Comment
a.	Final Detailed Business Case	22 March 2021	https://www.tewhatuora.govt.nz/assets/Health-services-and-programmes/Infrastructure-and-Investment/2_-_new_dunedin_hospital_final_detailed_business_case_0-v3.pdf
b.	Health Infrastructure Plan – Health New Zealand | Te Whatu Ora	16 April 2025	The Health Infrastructure Plan details the pipeline of investments in physical infrastructure over the next 10 years from IIG
c.	New Dunedin Hospital: Capacity Comparison Tables	July 2025	Annex 4 and online
d.	Approved Procurement Plan	2020	Available on request. Includes evaluation process and criteria
e.	Evaluation panel report/minutes	2021	Available on request
f.	Contractual documents	2025	CPB Agreement – form of contract can be provided
g.	Full list of financial assumptions	2025	Refer to the Financial Case for summary
h.	Change Management Programme for the New Dunedin Hospital (and supporting services)	June 2024	Version 1.0 - Available on request from Bridget Dickson, Programme Director, Southern Operational Readiness Team (SORT)

i.	**Southern Digital Programme Detailed Business Case**	**14 March 2022**	**Available on request from Phil Baskerville Programme Director – Digital Programme** **The total funding sought is $437m over two stages. Of which $131m is for stage 1 and the balance for stage 2 to be reconsidered in the future**
j.	Benefits Realisation Plan		Attached as Annex 6
k.	New Dunedin Hospital Project Assurance Plan	21 April 2021	Version 2.4 - Available on request
l.	Risk Management Plan	6 April 2021	V 3.0 – Available on request
m.	Project Management Plan	2025	Version 3 being updated - Available on request
n.	Stakeholder Communication Plan	July 2025	Available on request
o.	Risk Register – full registers	July 2025	Available on Request
p.	Gateway Review 2 (Delivery Strategy)	June 2020	Available on request
q.	Gateway Review 0 (mid stage Gateway Review)	December 2021	Available on request

Note: there are also various other background materials provided on the Health NZ website including past OIA responses

Appendix 2: Action plan and outcome of Targeted Investment Review

Ref	Recommendation	Priority	Response
R1	Proceed with seeking approval and confirmation of funding from decision makers, finalising the contract and commencing construction.	**DO NOW**	**Agree** – ImBC completed and subject to approval of this Cabinet paper

s9(2)(f)(iv)

R4	Clarify and communicate Project governance and management arrangements and how they connect with the overall governance of the NDH Programme	**DO NOW**	**Agree** - in progress

s9(2)(f)(iv)

R7	Review and update the Project Risk Management Plan and Risk Register.	**DO BY Sept 2025**	**Agree**

Progress against the seven Review recommendations will be incorporated into ongoing monthly reporting.

Appendix 3: Timelines for Delivery

Milestone	Date
Letter of Intent - date issued	30 June 2025
Early works commence (Pile Caps)	July 2025
Preliminary Design complete – Design Reset	August 2025
Developed Design complete.	October 2025
Pile Caps complete	December 2025
Detailed Design complete.	January 2026
Structure (Primary Steel) and Base isolators commencement	July 2026
Fitout commencement	March 2027
Façade commencement	August 2027
Façade finish	November 2028
Fitout complete	May 2029
Sitewide integrated commissioning completed	September 2029
Practical completion	**October 2030**
Go Live/Operational date	**February 2031**

s 9(2)(j)

s 9(2)(j)