Te Whatu Ora
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Capital & Infrastructure Committee

Meeting Minutes

Tuesday 19 July 2022. 4.00-5pm. Online via Teams.

In attendance:

Board: Rob Campbell (Chair), Hon. Amy Adams, Dame Karen Poutasi

Management: Graham Smith (Interim Chief, Infrastructure & Investment Group); Aaron Matthews (Director, Capital Investment); Monique Fouwler (Acting Director, Delivery); Catherine Foster (Board Secretary) Margie Apa

Apologies: Dr Curtis Walker and Vanessa Stoddart

No.	Item
1.	Karakia and mihimihi The Chair open proceedings with Karakia.
2.	Funding & Investment Overview G. Smith provided background on current funding, decision making environment, investment portfolio, and key risks. Key discussion points included: - DPMC is undertaking a 'deep dive' review of the Mental Health Infrastructure programme. Joint Ministers commissioned this review, and we are supporting the review, not leading it. **Action:** Share the review's Terms of Reference with Te Whatu Ora Capital and Infrastructure Committee for information. - Confirmation of total funds within the capital envelope. The total is $6.7b allocated to projects not managed as a total fund. - Gaining regional review of projects is essential to inform prioritisation decisions. There is a small opportunity that the board can take to reprioritise some spending across a small number of projects - Escalation costs are for total projects and included in a business case. Contingency is on top of these costs. - Risk: national understanding of assets is limited, making national decision-making difficult. Assessment of risk feels real and present for the Committee. - Quantity Surveying: The Committee suggested a panel be established to provide choice and competition. Furthermore, contracts can be rotated rather than renegotiated each time. The Committee found value in the paper and requested it is a standing agenda item providing an overview of capital, risk and issues.

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3.	Business Cases a. Whakatane Mental Health Unit Discussion points included: - The Committee did not feel comfortable endorsing the Business case to be presented to the Board on 29 July with the limited information presented. It acknowledges the importance of the project and their desire to see it progress, but more information was needed. - It's vital that Te Whatu Ora builds credibility with stakeholders so that we can manage capital projects effectively. The reputational and delivery risks are too high to proceed based on the information presented. - It remains unclear what regional assessment of needs has been undertaken to give the Committee and Board assurance that the project will meet community need - The Committee requested that a regional review, including the Tauranga Business case, is included to assess the trade-offs because there is not the money available within the envelope to do both projects based on current information. As a result of the discussion, the following process was agreed upon: Whakatane and Tauranga Business Cases are presented together for the Committee to assess projects and trade-offs. The Committee will recommend the preferred option to Te Whatu Ora Board and give it to the Minister for final decision. **Action**: The chair would write to the Minster, advising that the Committee, on behalf of the Board, requires more information before it can support the Whakatane Business Case.
4.	General Business **a. New Dunedin Hospital – Update on 'value management' exercise and implications** - Project is underway, and there is strong political support for the project. - The Committee needs assurance that the project can be built for the current budget since there is no more money to be allocated. - Establishing strong governance oversight of the project is a priority to ensure the project comes in on budget. - Local project management is an issue, and Te Whatu Ora team is wo king to ensure they have the appropriate skills and expertise to deliver a project on this scale. - Minsters have asked for advice on alternate financing options because there is no funding to allocate to the project. - The committee expressed that additional funding should not be sought from alternate sources and value engineering should be used to deliver the project on budget. - Committee discussed the contracts; there are separate contracts for the inpatient and outpatient builds, which were both under negotiation. It was confirmed that the Board would approve the contracts once negotiations were complete. An out-of-cycle meeting is possible if contract approvals are needed. - **Actions:** 1. Management to bring back to the Committee the proposed governance arrangements.

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	2. Committee to visit site and meet with stakeholders to communicate Te Whatu Ora's position on the project. **b. Forward work plan and next step requirements for Committee** Management and Board secretariat to work together to develop a forward work programme for the Committee.
5.	Whakamutunga The meeting closed at 5.20pm.

Next meeting/s:

- Friday 12 August (time TBC)

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Friday July 29. 9.30 am – 1.30 pm. Online.

Chair for the meeting Te Kaihautū mō te hui	Rob Campbell
Board attendees Ngā mema o te Poari	**In person:** Hon. Amy Adams, Tipa Mahuta (from 11.00 am), Dame Dr Karen Poutasi, Dr Curtis Walker, **Online:** Vanessa Stoddart
In Attendance Ngā manuhiri	**Te Whatu Ora**: Margie Apa (Chief Executive), Catherine Foster (Board Secretary) **In attendance for specific items:** • Rosalie Percival (Interim Finance Lead, Te Whatu Ora) • Dr Nick Chamberlain (National Director, National Public Health Service)
Apologies Ngā tamōnga	Tipa Mahuta joined the meeting at 11.00 am

Karakia and mihimihi

The meeting began at 9.34am.

C Walker opened the meeting with karakia.

Apologies were received from Tipa Mahuta for lateness.

Board members advised the following changes to the Interest Register:

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Dame K. Poutasi updated that 9(2)(a) [redacted]

Chair Report

The Board Chair provided a verbal update on

- Board appointments and committee membership. The Chair supported committees appointing independent members to ensure committees have appropriate expertise.
- Defining process for working with Ministers: The Chair h ghlighted the need for the Board to be involved in information and decisions presented to the Minister. It is important for management to clarify when the Board needs to be involved in communication with Ministers. Management welcomed a discussion from the Board on its risk appetite and matters of significance.
- Documenting decisions: There must be a record of what decisions are made by the Minister and by Te Whatu Ora Board/Management to provide visibility of decision-making and to manage budgets carefully.

Action: Board Secretary to provide a list of critical documents that the Board must see and sign off to assist with defining the Board's role and responsibilities.

Update from the Chief Executive

The Chief Executive's report was noted.

M Apa provided a verbal update on several matters. Key discussion points included:

- Workforce: The Board requested assurance that management is pursuing immediate outcomes for the workforce and that action is underway. The Board asked about the benefits of realisation of workforce initiatives to ascertain the effectiveness of investment. Speed in developing our workforce is critical for the Board and it is important for the workforce to see it prioritised. Policy papers are coming to the People and Culture Committee. However, long-term workforce strategy development remains a priority.

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- Holidays Act: People and Culture Committee will discuss this matter at their next Committee meeting including how to progress and pay workers their entitlement.

The Escalation of Adverse Events:

Board discussion points included:

- The Clinical Quality Assurance Committee signalled the intention to request Board time to run an educational session on clinical governance and processes and quality improvement and assurance
- Board highlighted the importance of an accountability culture regarding adverse events
- Learning and improvement must be core to how the system responds to adverse medical events
- Non-clinical accountability is also essential to understanding all aspects of the systems that may have led to an adverse event occurring
- The Board has a role in ensuring there are appropriate systems and processes in place to deliver the best level of care and that lessons are being learned while developing a culture of accountability (not blame).

BD018- 29 July 2022: The Board endorsed the Managerial process of escalation of adverse events, including

The basis for escalation of adverse events between district, regional and national management layers is proposed to be as follows:

- District staff identify the Severity Assessment Code (SAC) for the incident and continue reporting, investigating, addressing, and escalating as per their existing policies. The SAC level is determined based on the severity of the event and its impact on the patient, with levels 1-4. SAC levels 1 and 2 are the most severe and are reported to the Health, Quality and Safety Commission (HQSC), alongside any events on the 'always report and review list'.
- District Directors must escalate, as soon as is reasonably practicable, any adverse event incident that may attract media attention or lead to a significant reputational risk to Te Whatu Ora. Regional Director must decide whether they agree with the District Director's assessment. If so, the Regional Director must escalate the adverse event incident to the CEO and National Director of Medical.

- The CEO and National Director of Medical will then decide whether to escalate to Board, the Ministry and/or the Minister's office. Decisions will be made based on the 'no surprises' policy.
- All adverse event incidents escalated to the Ministers office will also be escalated to Board Chair contemporaneously.

Governance oversight of adverse event escalation:

- Regional Directors will be asked to provide a summary report of adverse events and any adverse HDC or coronial inquiries on a monthly or quarterly basis to align with the Clinical Quality Assurance Board Committee's rhythm and expectations for reporting. Management will take the Committee's advice on whether they wish to escalate the summary report to the entire Board.
- The Clinical Quality Assurance Board Committee will receive a copy of the Health, Quality and Safety Commission quarterly updates from their mortality and morbidity review committee, consolidating a view of events nationally. Management will take the Committee's advice on whether they wish to escalate this report to the entire Board.

T Mahuta joined the meeting at 11.00 am.

Other discussion points on the CE report included:

- Reporting metrics: GP contact rate tells how many patients are seen; however, looking at the waitlist and those not being seen is also valuable data. Telehealth statistics are also a useful metric as not all people contact GPs.
- Planned care: The Board requested further information on prioritisation criteria for Māori and Pacifica patients awaiting planned care. Clinically urgent care is the number one driver for prioritisation, followed by criteria such as waitlist time and age.
- COVID-19: As we live with COVID-19 in the community, funding is changing and will be reduced in some areas. Te Aka Whai Ora is interested in ensuring Māori providers are supported with a sustainable capacity to reach out to communities.

Action: Board Secretary to add a "reduction in COVID-19 care in the community funding" item to the Finance and Audit Committee work programme to understand financial risk.

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GOVERNANCE / BOARD ADMINISTRATION

Updates from Board Committees

Capital and Infrastructure Committee

R Campbell, Chair of the Capital and Infrastructure Committee, reported on the Capital and Infrastructure Committee meeting held on 19 July 2022. Committee discussed

- -Whakatane business case.
- -Update on Dunedin Hospital.

The quality of business cases was not at an appropriate level and it has been expressed to the team that the Board expects a quality improvement.

Items for Endorsement

R Percival joined the meeting at 11.45 am.

Te Whatu Ora Standby Credit Facility

BD019 – 29 July 2022 Board endorsed the recommendation to:

a. **note** that the iHNZ and iMHA Joint Working Group on Finance and Audit endorsed the approach described in this paper at meetings in May and June 2022
b. **note** that DHBs have required a SCF to manage short-term working capital fluctuations and treasury liquidity management purposes, and a similar facility will serve a similar purpose for Te Whatu Ora
c. **approve** a $200m SCF from Treasury on the terms proposed and delegates authority to the CFO to complete facility documentation by 30 September 2022

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d. **note** that consent for the facility will be sought from the Ministers of Health and Finance
e. **note** that the existing $50m SCF with BNZ will be discontinued immediately prior to the Treasury SCF commencing
f. **note** that this facility is separate from the $1.0bn Capital Contingency sum approved in Budget 22 for working capital, which is available through Ministry of Health (MoH) for all health entities, and that similar funds in the past have been used for funding operating losses and medium-term investments.

The CFO provided the following points for the Board regarding current challenges and risk:

Budget setting: Poor data quality has made it difficult to challenge and test budget assumptions. Never before has there been a holistic view of the health system's financial performance as it has been so fragmented.

Financial risks include:

- Lack of visibility of inherited decisions, prior commitments
- The expectation that things will be funded going forward will undermine the financial position
- Covid funding from Covid Recovery and relief fund is received differently to Vote Health funding. We must ensure appropriate cash flows in the first quarter to fund covid responses as required. We must be vigilant on these costs as Covid costs can escalate quickly if not tightly controlled.
- Valuations of buildings: Property valuations have risen materially and will impact depreciation expense.
- Planned care: inheriting a significant backlog. There is payment for something that hasn't been delivered, which Te Whatu Ora needs to adjust and presents inaccurate system performance expectations.

R Percival left the meeting at 12.12 pm.

Update from Te Aka Whai Ora

T Mahuta provided a verbal update from the Te Aka Whai Ora Board. Key discussion points included:

- At the Te Aka Whai Ora Board meeting held 27 July 2022 a key item for discussion was co-commissioning

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- Māori names and branding: Requested further information on what guidance is given on using local and Māori names. As the system matures and regions settle into their roles, brand image for a local identity will develop further. IMPBs will contribute to local identity.
- There will be a joint Te Aka Whai Ora and Te Whatu Ora board meeting on 18 August. Key agenda items will be co-commissioning, Kawenata and Waka Hourua relationship, and mental health.
- Monitoring: Te Aka Whai Ora is considering their monitor role and how they monitor for success and system improvement
- Te Aka Whai Ora is concerned about the Māori workforce disappearing as COVID-19 and community services are reduced
- Committees: Te Aka Whai Ora will nominate Board members to participate in Te Whatu Ora's Committees. Secretariats will work with Chairs to confirm arrangements.

National Public Health Service discussion with National Director

N Chamberlain joined the meeting at 12.25 pm.

The Board discussed the following points:

- Public Health Workforce: There is a focus on workforce wellbeing, workforce who have led the COVID-19 response are exhausted. Attracting Māori and Pacific into the workforce remains a priority, and we are working closely with Te Aka Whai Ora in this respect.
- National Public Health Service Structure: in place and agreed. Key roles include transformation, prevention, health promotion, protection, and assessment and surveillance. Director of Māori Public Health and Pacific Health are two new roles.
- Transformation: vision is to shift from public health service and expand into localities and engagement at a community level
- Policy: Working with the Ministry of Health and other government agencies to ensure public health is central to government policy and legislation. The Ministry of Health is an important partner. The Board will have a role in Public Health advocacy and work to consider where this sits and how to be most effective.
- Board Reporting: The Board and CE will receive a report on public health activities to ensure they oversee key activities.

N Chamberlain left the meeting at 12.59 pm.

Co-commissioning

The Board discussed the following points:

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- Co-commissioning is intended to be discussed at the joint meeting with Te Aka Whai Ora on 18 August
- Te Whatu Ora Board needed to articulate first principles to staff to ensure we got the best out of the discussion
- The Board had previously received a co-commissioning framework which would be recirculated to the Board to help them with their views of how best to work with Te Aka Whai Ora
- There are vital matters to consider, including legislative and contract management and the best services to be co-commissioned
- Co-commissioning will be discussed at the Public Health, Community and Primary Care Committee meeting on 12 August 2022.

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Board Administration

Register of interests: Noted. Amendments were advised as noted in the Karakia and mihimihi section of these minutes.

BD020 - 29 July 2022: Minutes and actions of the 15 July 2022 meeting were accepted as a true and accurate record of that meeting.

Actions register: Noted.

Meeting and engagements schedules: Noted.

General Business

The Board discussed there is an opportunity for lessons learnt from Te Pūkenga - New Zealand Institute of Skills & Technology.

Board expressed an interest in site visits to ensure Board members can discharge their governance accountabilities effectively.

The meeting closed at 1.10 pm.

The Board met in closed session.

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Actions from July 29 2022

(refer to separate Actions Register for a complete list, including status, of all interim Board open and closed actions)

No.	Action	Responsible owner	Due date
BD290722-01	Provide a list of critical documents that the Board must see and sign off to assist with defining the Board's role and responsibilities	Board Secretary	26.08.22
BD290722-02	Add a "reduction in COVID-19 care in the community funding" item to the Finance and Audit Committee work programme to understand financial risk	Board Secretary	26.08.22

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Capital and Infrastructure Committee

Meeting Minutes

Thursday 8 September, 3.00pm – 5.30pm. Online via Teams

Chair	Rob Campbell
Attendees	Board members: A. Adams, V. Stoddart, Dame K. Poutasi, C. Walker Independent Members: L.Ieremia, M. Johnston, S.Pritchard Te Aka Whai Ora: F.Pimm Management: G.Smith (Interim Lead, Infrastructure and Investment), M. Fowler (Director – Delivery | Pou Whakahaere Infrastructure and Investment), A. Matthews (Director – Capital Investment Infrastructure and Investment Group), C. Foster (Board Secretary)
Apologies	

No.	Item
1.	Out of scope [redacted]
2.	
3.	3.1. The Dunedin Interprofessional Learning Centre Discussion points included

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No.	Item
	9(2)(f)(iv) [redacted]
	Out of scope [redacted]

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No.	Item
	Out of scope [redacted]

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No.	Item
	Out of scope [redacted]

4.1. Project and Programme Governance – New Dunedin Hospital and other projects

Key discussion points included:

- Appropriate project governance is important for the Committee. Relook at recommendations b. as it currently reads like they capture all projects in place which is too board for the Committee to endorse. Emphasise that these arrangements relate to New Dunedin Hospital.
- Need to clarify SRO lines of accountability back to Board and reporting to Ministers.
- The Committee supported different governance arrangements for different projects and regions and different capabilities at different times. Not one size fits all.
- Focus on recruiting people with the right governance skill set who are respected by the Committee and can carry the weight of the issues. Need focus on governance skillset. And can carry the weight of the local issues.
- Committee noted that we spend too much time in design phase and carry a lot of risk during this phase.
- Committee want to see innovative practice coming through

The Committee supported the following recommendations:

a) **note** that the Ministry of Health has been requested to provide a report to the Minister of Health on governance arrangements at New Dunedin Hospital taking into consideration the recommendations of the latest Gateway Review.

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No.	Item
	b) **note** that the outcome of this paper will inform that report back along with a more general report being prepared on Capital Infrastructure Governance as required in the Capital Settings approved by Cabinet. c) **note** that Te Waihanga and Treasury have published guidance on establishing appropriate governance arrangements for major infrastructure projects d) **endorse** the establishment of a Project and Programme Governance Framework for Te Whatu Ora that follows the guidance from Te Waihanga and Treasury. e) **note** the current issues and confusion with project governance that exists with previously Ministry of Health led projects, specifically the Executive Steering Group (ESG) for New Dunedin Hospital and the Hospital Redevelopment Partnership Group (HRPG) for the Canterbury Rebuild. f) **endorse** the proposed changes to ESG and HRPG to align with best practice governance and the recommendations of the Gateway Review for New Dunedin Hospital.
	Out of scope

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No.	Item
	Out of scope, 9(2)(b)(ii)
5.	

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No.	Item
	Out of scope, 9(2)(g)(i) [redacted]
	Meeting closed at 5.17pm
6.	Karakia

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Data, Digital and Innovation committee

Meeting Minutes

9 September 2022. Online via Teams at 10.30am-12.30pm

Chair	Hon. Amy Adams
Attendees	Board members: Rob Campbell, Dame Karen Poutasi, Vanessa Stoddart. Te Aka Whai Ora: Mataroria Lyndon Management:, Stuart Bloomfield, Board Secretary: Catherine Foster Observer: George Smith
Invitees	Patrick Ng / Lance Elder (Southern Digital Business Case) Matt Lord / James Allison (Cyber) Daren Douglass (Portfolio Overview) Simon Ross (DISH) Delwyn Armstrong (Data Demonstration)
Apologies	

Item	Topic
1	Karakia Chair began the meeting at 10.30am.
2	Minutes and Actions from previous session The Committee noted the minutes as a true and accurate reflection of the meeting. Noted the Action list and requested that the Workforce Strategy for Data, Digital and Innovation also involves the People and Culture Committee.
3	What's going on in the world of DDI The Committee noted the update. Key discussion points included - Committee requested staff and contracting numbers across the data & digital directorate. This included headcount and contractor spend. - Hira: Confirmed that it is an ongoing agenda item for the committee and will be presented as a quarterly deep dive.
4	Southern Digital Business Case Patrick Ng and Lance Elder joined. The Committee noted the update. Key discussion points included

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- The Committee acknowledged the staff and how they had responded to the Committees request for more information on specific costs and rescoping of the project.
- Clarify that this is not a cost cutting exercise and the Board of Te Whatu Ora remain focused on delivering a modern, flexible and agile hospital. Need to focus on scoping a foundational initial product within scope and budget, leveraging nationally developed digital solutions where possible.
- Committee requested removal of the reference to Southern District Health Board which does not exist anymore. It is a Te Whatu Ora project.
- The committee discussed end-user infrastructure and received confirmation there will be options for clinicians to provide a range of digital services including telehealth.

Next steps

- The Committee requested business case information on the future digital solutions presented as part of the next phase of the work and how they can be leveraged nationally. Information should be presented to enable the Committee and Board to assess options (i.e. flexible and mix-and-match) rather than presented as an integrated package so the Committee and board can assess the trade-offs.
- Team confirmed it will take 4-5months to develop this national view and to understand alignment with other regions.

The Committee supported the following recommendations:

a) **Receives** this briefing paper which outlines a revised scope that is now aligned to foundational digital infrastructure and digital solutions in support of the New Dunedin Hospital Outpatient Building.

b) **Supports** the revised scope proposed for stage 1 investment.

c) **Recommends** this paper progressing to the te Whatu Ora Board for final endorsement prior to a request being made to Joint Ministers for stage 1 funding to be released.

6 DDI Committee paper, National Cyber Security Uplift Programme Update

Matt Lord and James Allison provided an overview. Key discussion points included.

- Resourcing is a challenge trying to recruit 70+ roles. Tension about contracting numbers vs. fixed term, particularly when capabilities are for development/uplift but not required permanently. There is a chance that lack of resource will delay programme.
- The Committee discussed redeploying resource from the districts; people are being brough in from across the system and roles are being advertised within Te Whatu Ora but skill gaps remain. The project requires specialised skills which is not always within District and Shared Service structures.
- The Committee noted the overspend for month of July. Management clarified this was a one-off (primarily due to the timing of licensing) and the forecast for

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the year is expected to be within budget. – **Action:** Board requested full year budget and how we are tracking on a forecast projection.
- The Committee discussed branding spend; it is important the project has a look and feel so people can engage with it and understand it's importance. However, the committee encouraged staff to use internal resourcing where possible to manage costs.
- Timing of information was out of date; Management will explore shifting reporting to better suits Committee and Board requirement for timely and accurate information.
- The use of external 3rd parties (e.g. EY, PWC) is being minimised, however still required in some areas.
- Maturity Scorecard: This will be available next year. Current focus is Primary Care data. The committee supported the Primary Care data focus and requested a report back on how the project is going and involving Te Aka Whai Ora who will have valuable inputs to be made.
- Resourcing: There is a need to clarify how the sharing of resources is being managed (funded/reported) with Te Aka Whai Ora. Management are seeking more information on this..

7 Data & Information Strategy for Health & Disability (DISH) Update

The Committee noted the paper. Key discussion points included:
- Programme was established be ore the Reform, however it remains relevant given it was designed to be agnostic to the structure and given national data is central to meeting the requirements of the 5 key shifts.
- Committee requested more information on the alignment with Hira. DISH and Hira are complementary: this project focuses on storing of data and building digital assets. Hira focuses on connecting data and enabling a person's health information to be brought together from different trusted sources and viewed as a virtual electronic health record. Hira delivers capability that are components of DISH and leverages capability that DISH is delivering.
- Discussed the challenge that historically a lot of the data has been collected for planning, funding and policy related work. Obviously under Te Whatu Ora, there is a now a more pressing demand for a national view of health data (ideally in real time, and at the patient level to support better analysis and insights in relation to things like demographics and equity of health outcomes).
- Committee requested more information of how 'it all fits together' (i.e. how the various projects interface and interact). This makes it difficult to assess investments and benefits. Management confirmed more information will be provided on this, as an output/outcome of the portfolio prioritisation work.

Delwyn Armstrong provided a demonstration of live data capture:

- Data is being collected at the patient level which has not been collected before, this is a new approach.
- The Committee noted that not all providers are sharing data. It requested that providers are compelled to share data through data sharing agreements and we

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must include this requirement in our commissioning contracts. Data provision should be tied to funding otherwise we have no way of assessing the value and performance of the service.
- There are privacy elements that needs to be considered and ensuring we have appropriate safeguards in place.
- Important that we consider wider sector data, not just hospitals as the system is larger now.
- Project aims to have data sets automated and viewed in real time.
- Next step is focus on analytics and what we do with the data we are capturing.
  Action: Add to future agenda item as data analytics is critical to transformation and new ways of working
- Hira is in the roadmap – Hira is about delivery information to people providing care.

The Committee supported the following recommendations:
- **Support** in principle the establishment of a common national data platform, encompassing secondary, primary and community care, and public health data.
- **Support** Data and Digital undertaking a six week discovery exercise to define the scope, engage the sector, and write a Request for Proposals for an industry partner for establishment of the national data platform.
- **Note** that this paper has been shared with the GM Data & Digital of Te Aka Whai Ora|Māori Health Authority and that Te Aka Whai Ora will take a lead in sector engagement within the six week discovery exercise.
- **Note** that this responds to an action within Te Pae Tata (interim Health NZ Plan) and is consistent with the Data & Information Strategy for Health & Disability.
- **Note** that the current Rapid National Data Automation project will inform the national data platform scope and approach, and delivers quick wins for the sector by linking district operational datasets at a national level.

Requested regular report backs on the programme to monitor progress.

8 D&D Portfolio Update

The Committee noted the update. Key discussion points included:
- Noted the Plan on a page and value of seeing the whole picture. Important to include the end user / consumer to ensure we are responding to need.
- Committee wants to understand how the plan relates to people and projects.
- Note that in the Portfolio space, all new work has stopped to review and reduce duplication and ensure alignment and consolidation of projects. This will help t ensure that the Data & Digital budget is treated as a single budget, with investments guided by the strategic oversight group.
- Governance oversight; investment prioritisation and decisions would be through a strategic oversight group. This is separate to the Clinical consumer group who will provide subject matter expertise. Need to consider ELT and CE lines of accountabilities and the role of the Board. Management confirmed the portfolio approach will be updated to explicitly include the CE and items escalated to Board based on delegated authorities framework.

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- Committee requested more visibility of major programmes and progress being made to assess the value of investment / benefits delivered. Management is establishing a single PMO to provide consistent data to support a portfolio view. Committee and Board will receive reporting as this is developed and comes on stream.
- Reporting cadence was discussed; Management to look at meeting cycle and work with Secretariat to ensure timely information is reported to the Committee and Board.
- Regarding committee cross-over; it is important there is an interface between the Capital Framework and Digital framework as there are many linkages. Visibility of physical and digital infrastructure important for decision making and planning.
- Operating model work will make clear the synergies and provide a line of sight to leveraging opportunities which nationalised system enables. Management intend to provide updates on this work at upcoming Committee meetings.

10 **Matters arising and next steps**

The Committee reflected on themes which connect with other Committee's workstreams. These included

- Data, Digital and Innovation workforce strategy
- Collection of Primary Health Data
- Data supporting clinical assurance and improvement
- Human Resource Information system important to stand up, along with national H&S data capture and reporting.
- Interface with capital investment framework
- Innovation at all levels.

11 **Discussion:**
Data, Digital and Innovation Committee Only

12 **Karakia**
Meeting closed at 12.30pm.

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Board paper

New Dunedin Hospital tender awards

Date:	18 October 2022	**Author:**	Monique Fouwler, Director – Delivery, Infrastructure and Investment Group
For your:	Recommendation	**Approved by:**	Graham Smith, Interim Chief of Infrastructure and Investment Group

Link to health sector principles (s7, Pae Ora Act)

Equity ☒	Engagement ☐	Opportunities ☐	Choice ☐	Health & wellbeing ☒
equitable access to services, levels of service, health outcomes for Māori and other population groups	with Māori and other population groups to develop and deliver services and programmes that reflect needs and aspirations	for Māori to exercise decision-making authority on matters of importance to Māori	provide choice of quality services to Māori and other population groups	protect and promote people's health and wellbeing

Purpose

1. The purpose of this paper is to:

   a) seek Board approval to award a construction contract to Southbase Construction Limited (Southbase) to deliver construction works known as Separable Portion One (SP1) to the new Dunedin Outpatient building by the end of 2025.

Contribution to Te Tiriti relationship and achieving equity or key system shifts

2. Te Whatu Ora is a key component to building a coordinated health system, to support all New Zealanders to live better and longer.

Recommendations

3. The Board is asked to:

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a) **approve** the award of the main contractor construction contract for the Separable Portion One Construction to Southbase Construction Limited for the New Dunedin Hospital Outpatient facility.

b) **agree to delegate** the signing of the Southbase Construction Limited contract to the Chief Executive or their delegate subject to legal assurance being provided.

New Dunedin Hospital

4. The final Detailed Business Case (DBC) for the New Dunedin Hospital (NDH) Project was approved in April 2021. Cabinet authorised the Minister of Finance and the Minister of Health to consider the Implementation Business Case for the Outpatient Building and the Inpatient Building prior to contract award [GOV-21-Min-0011].

5. In May 2022, Joint Ministers approved the Implementation Business Case for the Outpatient Building (attached at Appendix A) and authorised the award of a contract with Southbase (HR20220221).

6. Joint Ministers have already approved the award of the contract to Southbase Construction Limited in May 2022, and it is supported by the New Dunedin Hospital Executive Steering Group. There was a delay in signing the contract to establish more certainty around the costs.

7. Funding has been allocated to the New Dunedin Hospital programme of works. The funding for SP1 of the Outpatient build is within the quantity surveyors estimate.

8. More details are provided at Appendix 1 which is the paper that went to the Capital and Infrastructure Committee.

Engagement with Te Aka Whai Ora

9. This paper will be shared with with Te Aka Whai Ora | Māori Health Authority Board.

Next steps

10. Subject to Board approval:

a) the award of the SP1 contract to Southbase Construction Limited will facilitate contractor mobilisation which is programmed to commence 31 October.

Appendices

- Appendix 1: Capital and Infrastructure Committee Paper: New Dunedin Hospital Outpatients Building – Approval to award main contractor construction contract.

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Capital and Infrastructure Committee paper

New Dunedin Hospital Outpatients Building – Approval to award main contractor construction contract

Date:	6 October 2022	**Author:**	Monique Fouwler, Acting Director Delivery, Infrastructure and Investment Group
For your:	Approval	**Approved by:**	Graham Smith, Chief Infrastructure and Investment

Link to health sector principles (s7, Pae Ora Act)

Equity ☒	Engagement ☐	Opportunities ☐	Choice ☐	Health & wellbeing ☒
equitable access to services, levels of service, health outcomes for Māori and other population groups	with Māori and other population groups to develop and deliver services and programmes that reflect needs and aspirations	for Māori to exercise decision-making authority on matters of importance to Māori	provide choice of quality services to Māori and other population groups	protect and promote people's health and wellbeing

Purpose

1. The purpose of this memo is to seek approval to award a main contractor construction contract to Southbase Construction Limited (Southbase) to deliver construction works known as Separable Portion One (SP1) to the new Dunedin Outpatient building by the end of 2025.

Contribution to Te Tiriti relationship and achieving equity or key system shifts

2. Te Whatu Ora is a key component to building a coordinated health system, to support all New Zealanders to live better and longer.

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Health New Zealand

Recommendations

3. The Capital and Infrastructure Committee is asked to:

   a) **recommend that the Board of Te Whatu Ora** award of the main contractor construction contract for the Separable Portion One Construction to Southbase Construction Limited for the New Dunedin Hospital Outpatient facility.

   b) **recommend that the Board of Te Whatu Ora** delegate the signing of the contract to the Chief Executive or their delegate subject to legal assurance being provided.

   c) **note** that Joint Ministers have already approved the award of this contract to Southbase Construction Limited in May 2022 and it is supported by the New Dunedin Hospital Executive Steering Group.

Executive summary

4. A new Outpatient Building is being built in Dunedin. Construction on the new facility has started with the piling underway.

5. The construction will be split into two separate work packages known as Separable Portion One (SP1) and Seperable Portion Two (SP2). It is proposed that Southbase be contracted for initial construction works SP1 at a cost of 9(2)(b)(ii) [redacted]

6. Joint Ministers have previously approved the award of this contract to Southbase. However, there was a delay in signing the contract to establish more certainty around the costs.

7. One of the larger portion of the pricing for SP1 is the façade design, build and installation. SRG Global are new to façade supply in New Zealand but offer good value 9(2)(b)(ii) [redacted] and are recommended as the preferred façade supplier.

8. SP2 is subject to an open book procurement tender process and is being managed Te Whatu Ora with assistance from the project Quantity Surveyors Rider Levett Bucknall (RLB). It will be finalised within the next few months, subject to negotiation.

Background

9. The new Outpatient building will comprise five levels and a plant floor. The main services to be provided will be day procedures from four integral theatres, radiology, specialist clinics, a day medical unit and transit care and support services.

10. The final Detailed Business Case (DBC) for the New Dunedin Hospital (NDH) Project was approved in April 2021. Cabinet authorised the Minister of Finance and the Minister of Health to consider the Implementation Business Case for the Outpatient Building and the Inpatient Building prior to contract award [GOV-21-Min-0011].

11. In May 2022, Joint Ministers approved the Implementation Business Case for the Outpatient Building (attached at Appendix A) and authorised the award of a contract with Southbase (HR20220221).

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12. 9(2)(b)(ii) [redacted]

13. [redacted]

14. [redacted]

15. The Joint Ministers also authorised to contract (pre-construction services agreement) specific early trade packages in parallel with the main contractor procurement for the Outpatient building to avoid delays (HR20212223). The two separate procurement packages were for the façade and for structural steel.

16. 9(2)(b)(ii), 9(2)(g)(i) [redacted]

17. Whilst there has been a delay, the enabling and piling works are largely on track. Contractor mobilisation is programmed to commence 31 October if Board approval is received for the SP1 contract award.

Construction Scope

18. Southbase will be contracted for initial construction works known as Separable Portion One (SP1). SP1 includes the foundation works (but not piling), concrete works, steel, roof and façade. The cost of these works is 9(2)(b)(ii) [redacted]

19. 9(2)(b)(ii) [redacted]

20. The full scope of the Contract Works includes:

    a) completing the entire commissioned building from the piles up.

    b) completing civil and landscaping works in accordance with the plans and Resource Consent conditions.

21. Ceres New Zealand LLC and Marsh Ltd are undertaking the enabling and piling works.

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Construction Contract

22. The commercial terms negotiated with Southbase are consistent with other major projects. Of note:

    a) This contract is only for SP1 with the intention of agreeing SP2 later.

    b) 9(2)(b)(ii) [redacted]
    The project is expected to complete at the end of 2025.

    c) The fixed Preliminary and General price and Margin, façade and steel price has been agreed.

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

23. 9(2)(b)(ii) [redacted]

24. The main contract is based on a standard NZS 3910:2013 and recognised by the industry. It was drafted by Chapman Tripp and contained special conditions that have been agreed between Te Whatu Ora and Southbase. Chapman Tripp have provided a letter of comfort.

25 9(2)(b)(ii) [redacted]

26

Façade

27. 9(2)(b)(ii) [redacted]

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

28. 9(2)(b)(ii) [redacted]

29.

30.

31.

Financial Implications

32. Funding has been allocated to the New Dunedin Hospital programme of works. The funding for SP1 of the Outpatient build is within the quantity surveyors estimate.

Engagement with Te Aka Whai Ora (Māori Health Authority)

33. There has been no engagement with Te Aka Whai Ora. However, Mana Whenua is represted on the Executive Steering Group.

34. Aukaha, as representatives of the Mana Whenua, Kai Tahu have engaged with the design team since the concept design phase of the project in 2020. This consultation process covered both Outpatients and Inpatients and resulted in the gifting of the Cultural Narrative from Aukaha to the Design Team. Design elements that have been incorporated into the Outpatients design include:

    a) façade references of materials, patterns and forms representing, kareao the fish hook, Paua shells, fishing nets and sea shore flora.

    b) interior feature timber walls as the upturned waka.

    c) key viewshafts within the building that orientate towards significant local landmarks.

    d) Ara Honohono – connected pathway.

    e) dedicated Mana Whenua space.

    f) Wai Points.

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g) integration of appropriate Art Work internally.

35. Models of care have been reviewed with Aukaha ensuring that Mana Whenua needs have been incorporated.

Next Steps

36. On endorsement from the Committee, the Te Whatu Ora Board will be asked to approve the award the SP1 contract to Southbase Construction Limited. Contractor mobilisation is programmed to commence 31 October (subject to Board approval).

37. 9(2)(b)(ii) [redacted]

Appendices

- Annex 1: Health Report H20220221 New Dunedin Hospital: Outpatient Building Implementation Business Case
- Annex 2: New Dunedin Hospital: Outpatient Building Implementation Business Case

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Board paper

New Dunedin Hospital – Value Management

Date:	19 October 2022	**Author:**	Monique Fouwler, Director Delivery, Infrastructure and Investment Group
For your:	Endorsement	**Approved by:**	Graham Smith, Interim Chief, Infrastructure and Investment Group

Link to health sector principles (s7, Pae Ora Act)

Equity ☒	Engagement ☒	Opportunities ☒	Choice ☒	Health & wellbeing ☒
equitable access to services, levels of service, health outcomes for Māori and other population groups	with Māori and other population groups to develop and deliver services and programmes that reflect needs and aspirations	for Māori to exercise decision-making authority on matters of importance to Māori	provide choice of quality services to Māori and other population groups	protect and promote people's health and wellbeing

Purpose

1. The purpose of this paper is to update the Board on the value management exercise that has occurred at New Dunedin Hospital.
2. The paper requests the Board endorses the recommendations from Te Whatu Ora Capital and Infrastructure Committee which is presented as Option B in this paper.

Contribution to Te Tiriti relationship and achieving equity or key system shifts

3. The delivery of a new, modern, fit for purpose facility in the Southern Region will provide greater equity of access and services and improve health outcomes for Māori.

Te Whatu Ora
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Recommendations

4. The Board is asked to endorse the recommendations from the Capital and Infrastructure Committee, these are:

   a) **recommend** to Joint Ministers the value management scheme endorsed by the Project Steering Group that saves ~$90m but does come with some residual risk. The Committee acknowledged the $90m may be able to be saved. However, Te Whatu Ora cannot confirm the approach suggested is the best way forward.

   b) **note** to Joint Ministers that, subject to additional funding being made available, the Board's preferred option is option C that would save ~$35m and reduces the residual risk.

Background

5. The Detailed Business Case (DBC) for delivery of the New Dunedin Hospital (NDH) was approved by Cabinet in April 2021 [CAB-21-MIN-0124].

6. In March 2022, Joint Ministers agreed to a series of cost saving measures and the provision of an additional $111m in Budget 22 to address cost escalation estimates of $200m for the New Dunedin Hospital project. Joint Ministers noted that any further significant deviations from what has been agreed needed approval from Joint Ministers.

7. Value management activities since then have realised that it is not possible to achieve the savings articulated to Joint Ministers and further changes to the design would be required.

8. Due to the clinical and operational user engagement there has been leakage to other interested parties and stakeholders and the Joint Ministers requested a report on the value management activities and options for their consideration by 29 September 2022 (HNZ00004354 New Dunedin Hospital – Value Management).

9. Joint Ministers have already agreed to release the Crown contribution of $17m in the New Dunedin Hospital budget for the Interprofessional Learning Centre (ILC) to cover cost pressures and have invited a third party financing option as an alternative.

10. The Value management options were considered by the Capital and Infrastructure Committee on 13 October. The Committee requested management work to get better visibility of true costs with consideration for clinical risk, service planning, models of care, ILC, and OPEX.

Summary of the options

11. Three options have been put forward to Te Whatu Ora Capital and Infrastructure Committee. These are:

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a) **Option A:** Make no changes to the design of the New Dunedin Hospital and hence no capital savings and seek additional funding above the $111m allocated in B22 in future budgets if, or when, the escalation risk crystalises. In terms of design, programme, clinical, Iwi and stakeholder risk this option is least risky.

b) **Option B:** The recommended option of the Project Steering Group (PSG) saves an estimated $90m in capital costs but changes the design of the New Dunedin Hospital. With the inclusion of the $17m released from the ILC, this option would utilise $93m of the Budget 22 cost escalation provided. In terms of design, programme, clinical, Iwi and stakeholder engagement, this option is the most risky.

c) **Option C:** Design Lite recommended by Southern District Leadership. A hybrid approach that, albeit not tested, retains almost all the current design and save an estimated saving of $35m. With the inclusion of the $17m released from the ILC, this option would utilise an additional $37m of the Budget 22 cost escalation provided. This additional funding could be sought from future budgets if, or when, the escalation risk chrystalises. In terms of design, programme, clinical, Iwi and stakeholder risk, this option is more closely aligned to Option A and less risky than Option B.

12. The relative risks associated with each Option are outlined more clearly in the table below.

	Capital Cost	Operating Costs	Inpatient Construction Start	Inpatient Go Live	Design Risk	Clinical risk	Iwi and stakeholder risk
A. Base case	~$1,670m	Large bldg	April 23	June 28	Nil		
B. PSG Endorsed	~$1,563m ($90m + $17m)	Tsf of costs	January 24	March 29	Moderate		
C. Design Lite Option	~$1,618m ($35m +$17m)	Large bldg	April 23	June 28	Minor		

Engagement with Te Aka Whai Ora

13. This paper will be shared with with Te Aka Whai Ora | Māori Health Authority Board, for information.

Next steps

14. Post Board endorsement advice and options will be provided to Joint Ministers for their approval.

15. Once a final option is approved by Joint Ministers:

a) The project team will continue with the design and consultation as required.

b) A communication plan will be developed with the Minister's office for release as soon as possible.

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Appendices

- Appendix 1: Capital and Infrastructure Committee paper

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Capital and Infrastructure Committe paper

New Dunedin Hospital – Value Management

Date:	6 October 2022	**Author:**	Monique Fouwler, Director Delivery, Infrastructure and Investment Group
For your:	Endorsement	**Approved by:**	Graham Smith, Interim Chief, Infrastructure and Investment Group

Link to health sector principles (s7, Pae Ora Act)

Equity ☒	Engagement ☒	Opportunities ☒	Choice ☒	Health & wellbeing ☒
equitable access to services, levels of service, health outcomes for Māori and other population groups	with Māori and other population groups to develop and deliver services and programmes that reflect needs and aspirations	for Māori to exercise decision-making authority on matters of importance to Māori	provide choice of quality services to Māori and other population groups	protect and promote people's health and wellbeing

Purpose

1. The purpose of this paper is to update the Committee on the value management exercise that has occurred at New Dunedin Hospital and provide endorsement of the recommended option to the Board for them to provide to the Minister of Health and the Minister of Finance for approval.

Contribution to Te Tiriti relationship and achieving equity or key system shifts

2. The delivery of a new, modern, fit for purpose facility in the Southern Region will provide greater equity of access and services and improve health outcomes for Māori.

Te Whatu Ora
Health New Zealand

Recommendations

3. The Capital and Infrastructure Committee is asked to:

   a) **note** that cost escalation for New Dunedin Hospital has been estimated at $200m over what has already been allowed for in the $1.47b budget allocation.

   b) **note** that an additional $111m has been provided in Budget 22 to cover a portion of the cost escalation.

   c) **note** that to address the balance of the cost escalation, value management options have been developed for consideration by the Board and Joint Ministers.

   d) **note** that three options are available for consideration, all of which have more or less residual risk associated with them in terms of cost, design, programme, clinical, Iwi and stakeholder engagement.

   e) **endorse** to the Board that they recommend to Joint Ministers the value management scheme endorsed by the Project Steering Group that saves ~$90m but does come with some residual risk.

   f) **note** that Joint Ministers have already agreed to release the Crown contribution of $17m in the New Dunedin Hospital budget for the Interprofessional Learning Centre (ILC) to cover cost pressures and have invited a third party financing option as an alternative.

   g) **note** that the same options, with the Boards recommendation, was provided to Joint Ministers on 29 September 2022.

   h) **note** that this paper will be shared with Te Aka Whai Ora | Māori Health Authority Board but due to timing issues has not yet.

Executive summary

4. In March 2022, the Minister of Health and Minister of Finance (Joint Ministers) agreed to a series of cost saving measures and the provision of an additional $111m in Budget 22 to address cost escalation estimates of $200m for the New Dunedin Hospital project. Joint Ministers noted that any further significant deviations from what has been agreed needed approval from Joint Ministers.

5. Value management activities since then have realised that it is not possible to achieve the savings articulated to Joint Ministers and further changes to the design would be required.

6. Joint Ministers requested and were provided with a report back on the value management activities on 29 September 2022 (HNZ00004354 New Dunedin Hospital – Value Management).

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7. Three options are now available for consideration by the Board and Joint Ministers, these being:

   a) **Option A:** Make no changes to the design of the New Dunedin Hospital and hence no capital savings and seek additional funding above the $111m allocated in B22 in future budgets if, or when, the escalation risk crystalises. In terms of design, programme, clinical, Iwi and stakeholder risk this option is least risky.

   b) **Option B:** The recommended option of the Project Steering Group (PSG) saves an estimated $90m in capital costs but changes the design of the New Dunedin Hospital. With the inclusion of the $17m released from the ILC, this option would utilise $93m of the Budget 22 cost escalation provided. In terms of design, programme, clinical, Iwi and stakeholder engagement, this option is the most risky.

   c) **Option C:** Design Lite recommended by Southern District Leadership. A hybrid approach that, albeit not tested, retains almost all the current design and save an estimated saving of $35m. With the inclusion of the $17m released from the ILC, this option would utilise an additional $37m of the Budget 22 cost escalation provided. This additional funding could be sought from future budgets if, or when, the escalation risk chrystalises. In terms of design, programme, clinical, Iwi and stakeholder risk, this option is more closely aligned to Option A and less risky than Option B.

8. The relative risks associated with each option are outlined more clearly in the table below.

	Capital Cost	Operating Costs	Inpatient Construction Start	Inpatient Go Live	Design Risk	Clinical risk	Iwi and stakeholder risk
A. Base case	~$1,670m	Large bldg	April 23	June 28	Nil		
B. PSG Endorsed	~$1,563m ($90m + $17m)	Tsf of costs	January 24	March 29	Moderate		
C. Design Lite Option	~$1,618m ($35m +$17m)	Large bldg	April 23	June 28	Minor		

Background

9. The Detailed Business Case (DBC) for delivery of the New Dunedin Hospital (NDH) was approved by Cabinet in April 2021 [CAB-21-MIN-0124]. The DBC concept design comprised:

   a) Inpatient Building (including link bridges and an Ancillary Building located on the Bow Lane site): 77,591 m2

   b) Outpatient Building: 13,391m2

10. The DBC identified clinical service capacity requirements out to year 2043 based on a high efficiency service demand model. It acknowledges a risk that demand may exceed forecast, or that efficiency assumptions may not be achieved, and it therefore highlights the need for expansion capacity in key areas such as ICU beds and theatres. Of note the hospital was to include:

    a) 410 Beds including 30 ICU or high dependency beds (expandable to 40).

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b) 16 Acute, Elective and Same Day Theatres (expandable to 20).

11. In addition to the above clinical requirements, the Business Case also commits to:

a) The design future proofing for flexibility and immediate easy expansion based on the principle of 'long life, loose fit'.

b) A carbon neutrality programme and a 5-Star Greenstar accreditation target.

c) Pandemic readiness planning.

12. In March 2022, in response to forecasted cost escalation of $200 million on the budgeted $1.47 billion, the Ministry of Health provided a briefing to Joint Ministers [HR20220041 refers] on options to achieve savings between ~$50m and ~$200m.

13. Joint Ministers agreed to an option that indicatively achieved $89m in savings and provided a budget top up in B22 of a further $111m, to meet the forecast budget shortfall. The option chosen by the Joint Ministers had the following key features:

a) Removal of the Pavilion Building and incorporation of the components into the Logistics and Inpatient Buildings, enabled through the reduction of clinical and non-clinical areas.

b) Retention of one link bridge between Inpatients and Outpatients buildings.

c) Third party financing of the ILC - releasing $17m additional budget to cover cost pressures.

d) Value engineering of the façade.

e) Reduction of the Major Medical Equipment (MME) budget.

f) Delivery of the Mental Health Services of Older People IPU service in the community.

14. A key underlying assumption to the recommended option provided to Ministers was that it avoided major re-design of the Inpatient Building and risks associated with significant programme delays due to re-undertaking the Concept and Preliminary Design which would create addition escalation pressures. The Inpatient Building is currently 75% of the way through Developed Design.

15. Subsequent to that advice, more detailed investigations were undertaken and it became clear that the approach outlined to Joint Ministers would not yield the savings as envisaged.

16. In May 2022, the project team began a detailed design optimisation study to further develop and refine the above option, with a target of realising a net $100m saving.

17. A key consideration was the need to minimise programme impact both in terms of redesign and Inpatient Building opening date, as offsetting associated time related costs significantly increases the building savings required to be achieved.

18. The project team explored and tested various design schemes as part of the optimisation study with an aim to achieve the required savings by:

a) Improving building efficiency through bulk and form.

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b) Refining building systems and materiality.

c) Maximising building spatial use and efficiency.

d) Minimising the required reduction of day-one clinical services and capacities.

e) Minimising the extent of clinical replanning.

f) Utilsing collaborative workspace flexibility (by taking a distributed approach).

g) Minimising loss of building resilience and energy efficiency.

h) Minimising any adverse impact to building maintenance and operation.

19. Design exploration and associated clinical/operational user engagement resulted in an iterative design process and development of a scheme that resulted in an estimated net saving in capital costs of $90m.

20. Due to the clinical and operational user engagement there has been leakage to other interested parties and stakeholders and the Joint Ministers requested a report on the value management activities and options for their consideration by 29 September 2022 (HNZ00004354 New Dunedin Hospital – Value Management).

Key Design Changes

21. The key changes from the current developed design, in addition to that already agreed by the Joint Ministers, that were presented to the Project Steering Group are attached in Appendix 1. A summary is provided below:

a) Removal of logistics building and replaced with a generator and heat pump chiller facility.

b) Inpatient building repositioned to enable Loading Dock to the south and future develop site to the north.

c) Reduction in Inpatient Unit bed numbers by 32.

d) Remove of the 24 older persons mental health inpatient beds.

e) Reduction in fitted out theatres from 16 to 15 and 2 fewer shelled theatres ie. 3 fewer theatres in total.

f) Removal of the PET/CT scanner.

g) Removal of Pharmacy Production Unit.

h) Reduction in Pathology Lab space to a 24-hour Collection Point / ‘Hot Lab’ for acute clinical functions.

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Key Design, Programme and Financial Risks and Issues

22. The key risks and issues noted by the project team of the recommended option are:

a) The value managed schemie is at a feasibility/concept design stage and will require the project to revisit preliminary design for the new and significantly impacted design elements. With respective to the existing Inpatient Building design, significant changes include spatial replanning for Level 0, 1, 2, 3, and 6, and the Level 3 and 10 plant rooms.

b) Therefore, there is a level of design development required to fully verify the scheme both technically and functionally with users, and in terms of understanding and quantifying the delivery impacts. The project team proposes to incorporate a fast track 'key user' engagement and design review and approvals processes for the revisited Preliminary Design and Developed Design phases. Enabling a seamless redesign will be essential for minimising programme impact.

c) The impact on programme is forecasted in the table below.

	Current Programme Rev 4.	Optimisation Programme	Delay Impact
Design (prolongation to 100% Detailed Design Completion)	August 2023	September 2024	12 months
Inpatient Building Construction Start (piling)	April 2023	January 2024	9 months
Inpatient Building Opening "Go Live"	June 2028	March 2029	9 months

Note:
a. The above dates are forecast on Te Whatu Ora approval to commence redesign as of 16 September 2022
b. Programme 'Delay Impact' is not cumulative.

d) A high level feasibility estimate of the net savings achieved for the value managed scheme has been provided, a summary of which is in table below.

Estimated Cost Saving

Building Cost Saving:	$ 117,000,000
Less:	
Consultant Fees:	$ 12,000,000
Escalation:	$ 15,000,000
Estimated Net Project Saving:	**$ 90,000,000**

e) Actual savings achieved will not be confidently known until the design has gone through the Preliminary Design and Developed Design phases which are forecast to extend out to December 2023. Cost checks will be undertaken at the conclusion of each phase given their short durations of 5 months and 6 months respectively.

f) Other financial risks include:

i) Redesign programme not being achieved or enabled due to consenting, stakeholder engagement, approval processes, and ability to progress early procurement of critical trades.

ii) Escalation rates applied being exceeded.

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iii) Interior design replanning impacted by unforeseen obstructions (e.g. new risers) or clinical requirements.

iv) Building services value management savings not obtaining final agreement.

v) Consultant fee variations exceed budget allowance.

vi) Unanticipated urban design requirements.

Clinical and Operational Risks and Issues

23. In response to the project teams report, Southern Clinical Leadership issued a Clinical Impact Statement and Report. These are attached in Appendices 2 and 3. In summary it noted the following:

    a) The current design for the New Dunedin Hospital has taken four years of careful planning.

    b) There has been insufficient time to enable a full consideration of the clinical risks on the value management option recommended to the ESG, for example:

        i) Critical loss of bed capacity leading to a sustained and high risk of patient harm along with significant impacts on planned care and operational failure.

        ii) The impact of space reduction allocated to Pathology services will require an in-depth study of the requirements for delivery of a two+ site pathology service.

        iii) The proposed changes to Mental Health Services for Older People (MHSOP) Unit will require a regional study into a new model of care approach for delivery of this service.

        iv) National strategic direction for provision of PET-CT.

        v) Regional planned care provision.

    c) There has been insufficient consideration of the operational cost or deferred capital cost impact of the proposed changes, for example, moving services (partially or fully) out of scope of the NDH still requires a facility to be provided.

    d) Mana whenua and stakeholder groups have been well engaged in the design process to date but have not had the opportunity to fully detail the impact of the proposed option from their perspective.

24. In response to the Clinical Impact Report, the Project Steering Group have agreed to

    a) Reinstate the 32 inpatient beds at a cost of ~$9.8m; and

    b) Reinsate 12 of the 24 acute older persons mental health beds at a cost of ~$6m.

25. The additional cost of $15.8m will be funded from the design contingency. Total design contingency for Inpatient Buildings is $34.53m with no contingency spent to date – see Appendix 4 for overall project contingencies.

26. However, even with the reinstatement of 44 beds it still leaves the New Dunedin Hospital with 12 fewer beds than in the current business case.

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27. The balance of the older persons mental health beds would look to be delivered in community, however, there is currently no funding allocated to deliver the remainder of the beds nor is the model of care sufficiently developed to fully understand the number and types of beds required.

28. Clinical representation on the Project Steering Group make the following comments in relation to residual clinical risk:

    a) It is good to see the beds reinstated in the model as that provides immediate flexibility for future growth and changes in model of care.

    b) It is also good to see Southern accept that the model of care for MHSOP needs review and that might result in fewer inpatient beds releasing space for future flexibility e.g. adult med/surg growth.

    c) The plan to move the kitchen allows for the Ops centre and clinical engineering to move. Arguably the Ops centre will be in a better place closer to ED.

    d) There is sufficient shared space for teams and meetings – noting that so many more people now work from home or zoom from other sites.

    e) It is reassuring to see the Operating Room shells for the future retained. Overall there is plenty of capacity for future growth.

    f) The building is impressive, large and future proofed and will allow for greatly enhanced safety and clinical/patient/family experience. Key colocations have been preserved.

    g) There is never enough money for every clinical desire to be realised but the designers have done a great job and the clinical leadership team have been very constructive in ensuring preservation of key spaces and future resilience.

29. To further mitigate the design and clinical risk, the project team are looking to engage a health planner to provide independent advice as the design progresses.

Alternative Proposal

30. The Southern District Leadership Team have provided an alternative proposal that they believe addresses many of the key risks and issues associated with the Project Steering Groups recommended value management scheme by adopting a ‘design lite’ approach.

31. Essentially, the alternative proposal retains the Pavilion and Logistics Building and the current design of the Inpatient Building except:

    i) Staging approach including radiology (cold shell 1x MRI and 2x x-rays), cold shell PET-CT and hybrid 1x down spec.

    ii) Removal of blue bridge.

    iii) Cold shell 12 beds MHSOP.

    iv) Adjusting the single: twin ratio from 75% to 62% in inpatient wards.

    v) Redistributing work space in the Pavilion Building to the Inpatient Building.

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vi) Deleting a floor off the Pavilion Building.

vii) Deletion of two theatres.

32. They acknowledge that this option has not been investigated by the Project Team but based on information they have to hand they have estimated a potential $35m capital saving whilst also incurring far less clinical, operational and design risk.

Overview of Options

33. There are essentially three options available in response to the cost escalation pressures for the New Dunedin Hospital. These are:

a) Retain existing design and seek further funding when the escalation risk chrystalises:

This option acknowledges that escalation risk of $200m has been presented and that there is currently $111m additional funding set aside in B22 that contributes toward the mitigation of that risk. Given the market uncertainty at the current time, it is not known whether the $200m will be the final escalation cost or not. In a year or two's time, when costs are better understood and impacts on remaining budget can be assessed including remaining contingency, further funding may or may not be required.

b) Undertake value management option as recommended by the Project Steering Group:

This option saves ~$90m in capital costs but increases programme, operational, clinical and stakeholder risks. As per the above, given market uncertainty it is still not known whether the savings and additional budget allocated will be sufficient to cover escalation risk and further funding in the future may be required. With the addition of the $17m released from the ILC contribution provides a $107m reduction in funding required, calling on only $93m from the Budget 22 allocation.

c) Design Lite option recommended by Southern District Leadership:

This option is a hybrid approach between Options A and B. It has not been tested by the project team but seeks to reduce ~$35m in capital costs, whilst minimising or eliminating the clinical, operational, programme and stakeholder risks. The same risks relating to escalation hold for this option also. With the addition of the $17m released from the ILC contribution this options provides a $52m reduction in funding required but would therefore require a funding top up of an additional $37m over the Budget 22 allocation or from future budgets.

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34. The table below shows the key design changes to the current developed design:

	# of IP Beds	# of theatres	PET CT Scanner	MRI	General X-Ray	Pathology Laboratory	MHOPU beds	Pavilion Bldg	Logistics Bldg
A. Base case	410	16 Exp to 20	1	3	8	1 (shell)	24	Remains	Remains
B. PSG Endorsed	398	15 Exp to 18	0	2 Exp to 3	6 Exp to 8	Reduced to 24hr hot lab/collection shell	12?	Removed	Removed
C. Design Lite Option	398 expandable to 410	15 Exp to 18	1 (shell)	2 Exp to 3	6 Exp to 8	1 (shell)	12?	Remains – 1 floor	Remains

35. The table below shows the impact of each proposal on key risk elements, with the original design being used as the base case for comparison.

	Capital Cost	Operating Costs	Inpatient Construction Start	Inpatient Go Live	Design Risk	Clinical risk	Iwi and stakeholder risk
A. Base case	~$1,670m	Large bldg	April 23	June 28	Nil		
B. ESG Endorsed	~$1,563m ($90m +$17m)	Tsf of costs	January 24	March 29	Moderate		
C. Design Lite Option	~$1,618m ($35m +$17m)	Large bldg	April 23	June 28	Minor		

Engagement with Te Aka Whai Ora

36. Te Aka Whai Ora have not been engaged to date on the New Dunedin Hospital but Ngai Tahu are represented on the Project Steering Group and mana whenua have been engaged over the last four years in relation to the design.

37. There have been several briefings and follow-up co-design workshops held with Aukaha and Mana Whenua representatives on the optimisation process and resultant options. Whilst Aukaha expressed that the loss of the Pavilion Building and 'cloak' façade has been disappointing, there has been understanding of the context and need for savings in the discussions to date.

38. The Mana Whenua panel continue to discuss whether the interim project name of "Whakatuputupu" will remain or be withdrawn. It is envisaged that all other aspects of the Māori Models of Care and the Cultural Narrative will continue to be represented appropriately in the Project Steering Group Scheme. It should be noted that sufficient time and budget fee allowance needs to be made to allow for the future co-design process with Aukaha and mana-whenua, to achieve the appropriate expressions of the cultural narrative in the Inpatients Building and landscape design.

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Conclusion

39. The current design process is approximately 75% of the way through the Developed Design phase. It is unusual that such a significant level of cost saving is required to be found at this stage of the process. Nonetheless, the project team consider that there have been some significant efficiencies and savings found that nearly achieves the full business case scope which would result in a capital saving of ~$90m.

40. The Project Steering Group agreed that the 32 bed IPU be retained and funded through the release of design contingency. In terms of the older persons mental health beds, the Project Steering Group also recommeded that there was a need for acute Older persons mental health beds and that a portion of contingency should be released to reinstate an as yet unspecified number of beds, but for planning purposes the design is accounting for 12 beds. There remains a need for further engagement to address other issues raised in the Southern Clinical Impact Statement with a view to resolving them where possible as part of the design process.

41. Te Whatu Ora Southern Leadership recommended an alternative option of keeping the design developed to date including the Pavilion Building. The approach would involve cold shelling or staging of components of the current design (estimated $35m) and avoiding additional costs for professional fees and programme delay.

Next steps

42. Post Board endorsement advice and options will be provided to Joint Ministers for their approval. Once a final option is approved:

    a) The project team will continue with the design and consultation as required.

    b) A communication plan will be developed with the Minister's office for release as soon as possible.

Appendices

There are four appendices to this paper.

- Appendix 1: Value Management Report recommended by Project Team to the Project Steering Group
- Appendix 2: Clinical Impact Statement
- Appendix 3: Southern Leadership Response on Option B
- Appendix 4: New Dunedin Hospital Contingency Status as at September 22

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Capital and Infrastructure Committee

Meeting Minutes

Thursday 13 October, 08.30am-11.45am. Online via Teams

Chair	R. Campbell
Attendees	Board members: A. Adams, N. Ferguson Independent members: L. Ieremia, M.F. Johnson Te Aka Whai Ora members: F. Pimm Attendees: M. Apa (CE) G. Smith (Interim Chief, Infrastructure and Investment Group), A. Matthews (Director – Capital Investment, Infrastructure and Investment Group), M. Fouwler (Director Delivery, Infrastructure and Investment Group) For item 5.1 W. McNee (Independent Chair, Infrastructure & Data & Digital Operating Model Working Groups)
Apologies	Scott Pritchard, V. Stoddart Apologies for M. Apa until 9.30am.

No.	Item
1.	Out of scope
2.	
3.	Out of scope

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No.	Item
	Out of scope [redacted]

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No.	Item
	Out of scope, 9(2)(f)(iv)

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No.	Item
	3.4. New Dunedin Hospital tender award for Outpatients Building The Committee endorsed the following recommendation: a) **recommend that the Board of Te Whatu Ora** award of the main contractor construction contract for the Separable Portion One Construction to Southbase Construction Limited for the New Dunedin Hospital Outpatient facility. b) **recommend that the Board of Te Whatu Ora** delegate the signing of the contract to the Chief Executive or their delegate subject to legal assurance being provided. c) **note** that Joint Ministers have already approved the award of this contract to Southbase Construction Limited in May 2022, and it is supported by the New Dunedin Hospital Executive Steering Group.
	3.5. New Dunedin Hospital Value Management Key discussions - Committee is not clear if value management recommendations are clinically endorsed. It was confirmed the MHOP doesn't yet have model of care developed. Unclear that there will not be duplication of service in pathology in the future. - Concern that redesign will result in costs and time associated. - Committee supported working with Ngai Tahu. - Interprofessional Learning Centre: 9(2)(f)(iv) [redacted] - Committee noted the Project Steering Group and their recommendations, but it isn't in a position to endorse their views. - The Committee can't recommend decisions to the Board for funding we don't have. - Options available to consider include private equity, phasing of build and progressive contracting arrangements. Value can be added by taking different approach. - Still work to be undertaken to get confidence in the project's costs; have not completed detailed design. - Need to also consider operating costs in Capital Plans. - Need to consider consequential of the options when presenting their recommendations in future. - Committee need to test the PSG and local team's recommendations as it is not clear that their endorsements can be supported based on the information presented to the Committee. **Recommendations deferred:** **Action:** The Committee requested management work to get better visibility of true costs with consideration for clinical risk, service planning, models of care, ILC, and OPEX.

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No.	Item
	Recognising this project is in flight, 9(2)(g)(i) [redacted] 9(2)(f)(iv) [redacted] **3.7. Proposals for project closure** Key discussion points - It is unclear of Te Aka Whai Ora's involvement in the meeting material at either a management or governance level. **Action:** Clarify process for sharing information across both entities and identify who has been involved and at what level. Out of scope [redacted]

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No.	Item
	Out of scope
4.	
5.	

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No.	Item
	Out of scope
6.	
7.	
9.	

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No.	Item
	Out of scope, 9(2)(b)(ii)
10.	

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No.	Item
	Out of scope
11.	
12.	

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Capital and Infrastructure Committee

Meeting Minutes

Thursday 8 December, 8.00am-10.30am. Online via Teams

Chair	Naomi Ferguson
Attendees	Board members: Amy Adams Rob Campbell Vanessa Stoddard Jeff Lowe Dame Karen Poutasi Independent members: Lale Ieremia Scott Pritchard Mei Fern Johnson Management: Margie Apa (Chief Executive) Graham Smith (Interim Chief, Infrastructure and Investment Group) Jeremy Holman (observing) Board Secretary: Catherine Foster (Board Secretary) In attendance for specific items: Emma-Kate Hill Kirsty Shepherd Aaron Matthews Monique Fouwler
Apologies	Mei-Fern and Margie joined at 8.30am. Apologies from Fiona Pimm

Karakia
The Chair opened the meeting with Karakia at 8.00am.
1. Recap of previous meeting
1.1. Confirmation of Minutes

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The minutes were accepted as a true and accurate reflection of the meeting.

Matters arising:
Management confirm Whakari is not listed as a priority of Te Pae Tata.

1.2. Action Register
The Committee's actions were noted without discussion.

Committee recommend close action 2, noting seismic will be a priority for the Committee and captured in forward work programme.

1.3. Register of Interests
The Committee noted the Register of Interests.

2. Items for recommendation to the Board of Te Whatu Ora

2.1. New Dunedin Hospital
Key discussion points included:

- Committee noted that the project is in the early stages of its lifecycle and, therefore, redesign is unlikely to realise significant savings. It is a reduction in scope.
- Committee recommended that management work without a contractor to find savings and avoid the trap of finding short-term savings for a project of significant scale.
- Further savings should be considered across the project lifecycle, including procurement strategy.
- There is a risk that we are underbuilding, cutting back services and still need to quantify operational costs. These risks need to be visible to Minister, Board and Management.
- The Committee discussed the clinical safety of the options presented. Management confirmed that clinical advisers had affirmed their support for option B; however, there is a difference of opinion between the clinical team and the clinical advisors on ESG. The Committee requested that this is clearly articulated, documented, and visible to decision-makers where the difference lies and why option B is being recommended. **Action:** Management develops a file note which captures the project history and lessons to work with other agencies of large capital infrastructure projects to result in better outcomes.
- The Committee requested assurance from management that future models of care are considered in the scope and design of the project.
- The Committee requested information on operational costs. The Committee noted that these are early stages of projects, and we don't have all the supporting documents to provide accurate operational cost visibility.
- Committee also wants to ensure that the expansion of its footprint and services will be possible in the future. We must build flexible spaces that scale and adapt as the population needs to evolve.
- Committee requested management provide the cost per m2 as an appropriate benchmark for the prices.
- Te Aka Whai Ora's view is that they did not feel appropriately consulted on the project. As a result, they requested to continue to be consulted with Te Aka Whai Ora and Mana Whenua.

The Committee agreed to:

a) note that further work has been undertaken on the New Dunedin Hospital Value Management
a) note that Treasury and Ministry of Health has sought clarification on the Boards endorsements

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b) note that some of the clinical risks identified for Option B have been further mitigated, noting it is very early in the development and management will work with contractor to continue to realise costs savings
c) recommend that the Board endorse Option B only as, upon further investigation, Option C does not produce the savings indicated or necessarily reduce the clinical risk as advised. There are still clinical risks that the Committee will need to review including clinical pathways and future growth and demand of the project as the project develops. Noting the Committee is working on the basis that there is not further funding available for this project.
d) note that upon endorsement Option B will be recommended to Joint Ministers for their approval.
e) Note a file note will be developed to provide visibility of key decisions taken and lessons learnt for other large-scale projects the Board will be responsible for delivering
f) Note that there will need to be further consultation with Te Aka Whai Ora and mana whenua

Next steps:

- Management to prepare an out-of-cycle paper for the Board to endorse, noting the small timeframe of getting advice to Ministers.

2.2. Bay Of Plenty – Mental health business cases for Whakatāne and Tauranga

Key discussion points included:

- Information on seismic risks on the Whakatane Site is emerging and requires revision of the current options for the proposed mental health facility.
- The Committee interrogated the scale of funding in these projects, including s 9(2) of life-saving work in Tauranga, which is a significant portion of the project's budget. Management confirmed that the previous DHB had earmarked depreciation funding for these works. Therefore, the Committee affirmed their expectation that these works is funded from Opex-maintenance budgets and not new capital.
- Management stated to the Committee that there are risks with the Whakatane site, and its ability to remain open may be at risk if not addressed.
- The Committee requested that Ministers be made aware of the issues with Whakatane to ensure they have visibility.
- The Committee noted the importance of undertaking urgent work to address the safety issues, keep the facility open, and manage the identified risks.
- The Committee noted that service planning and management of patients would also need to be used to actively mitigate risks.

The Committee agreed to:

a) note that since the November Capital and Infrastructure Committee meeting, the Infrastructure and Investment Group has received a report from GNS Science, Te Pū Ao which provides revised information regarding the Whakatāne fault line location that requires revision of the current options for the proposed mental health facility.
b) note that the Tauranga case is discussed in the paper also to ensure the Bay of Plenty district business cases continue to be considered together.
c) recommend to the Te Whatu Ora Board, that the Tauranga Business Case as the preferred option for the funding of an extension of the facility at a capital cost of s 9(2)(a)

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d) recommend to the Te Whatu Ora Board, that the Infrastructure and Investment Group address urgent works at Whakatāne up to s 9(2)(a) . Noting that Management must utilise depreciation funding, not new capital.
e) Noting Committee wants work done to mitigate the current risk to patients in the facilities recognising that response will be both clinical and structural.
f) recommend to the Te Whatu Ora Board, that management redevelop a business case for the Whakatāne mental health facility by the end of 2023 to identify options and align with regional planning.

2.3. Cost pressure funding decisions.

Key discussion points included:

- Committee requested further information on why MidCentral Mental Health Facility is at 71% cost escalation. Management confirmed contractor availability is driving cost increase. Action: Management to analyse this closely and provide more information to the Committee.
- Committee requested further information on how escalation impacts HCE, as table 2 is unclear. Management confirmed that available funding relates to escalations across the escalation of the health capital envelope portfolio.
- The Committee requested that Management uses accurate language and note the difference in genuine cost escalation and scope change. We must understand the difference to make intelligent decisions.
- Committee suggested Management deploy specific research to analyse business cases that have yet to be developed using a best practice approach to understand better the potential risks of cost escalation and the need for changes in scope.
- The Committee requested data support recommendations the Committee is asked to support, including evidence of pro-equity models of care.
- The Committee wanted to see a national approach to managing the portfolio and more intelligence on addressing trade-offs and future funding requirements.
- Important to work closely with Ministers on announcements to ensure projects can be delivered to the budgets set.
- Committee noted the importance of a national asset management plan and a key tool to discuss priorities with the Minister.
- Action: The Committee requested that the paper makes clear what is scope change, escalation or emissions in planning to understand what is driving project costs.
- Committee noted the importance of clinical service planning to match infrastructure planning.

The Committee agreed to:

a) **note** this paper follows the 'Proposed management of cost pressures' paper considered by the Committee in November and seeks the allocation of additional funding from the Health Capital Envelope for eleven projects representing critical cost pressures that require immediate resolution.
b) **recommend** that the Board endorse s 9(2)(a) in already committed capital as part of a cost escalation obligation, to be allocated from the HCE to projects that have cost increases incurred through existing contractual commitments.

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c) **recommend** that the Board endorse s 9(2)(a) in capital to be allocated to projects experiencing cost increases, where these represent a significant risk to service delivery or project interdependencies.

d) **recommend** that the Board endorse s 9(2)(a) in capital funding to be allocated to the following projects within the Mental Health Infrastructure Programme, which are in the tender process and are approaching contract signature.

e) **Note** the Committee requested management provide more information on the MidCentral Mental Health Facility cost escalation of 71%

f) **note** the Infrastructure and Investment Group will continue to monitor value management activities for the projects in sub-paras d. and e. and will report any savings realised to the Board in future portfolio updates.

g) **note** that endorsement of the Board following the recommendation of the Committee will be the basis of a note to the Minister of Health and Minister of Finance, seeking confirmation of the funding requests.

h) **recommend** that the Board approve the release of this paper to Manatū Hauora and the Treasury.

i) **Note** the committee requested recutting of table two to make clear what is escalation and what is scope change.

2.4. Waikato Renal – Implementation business case

Key discussion points included:

- Committee requested assurance that mental health funding can be used for this project. Management confirmed that Treasury s aware and agrees with approach.

The Committee agreed to:

a) **note** that the Minister of Health approval of funding included a requirement for the project to submit an implementation business case for the investment.

b) **note** that the Infrastructure and Investment Group has reviewed this (pre-deal) iteration of the Implementation Business Case and recommends it progresses for approval.

c) **note** that if there is an increase in funding requirements the Implementation Business Case will be re-submitted to the Committee.

d) **recommend** the Te Whatu Ora Board the approve the (pre-deal) iteration of the Implementation Business Case for WRRC.

e) **recommend** the Te Whatu Ora Board delegates approval of the contract to the Te Whatu Ora Chief Executive, or delegate.

2.5. Alternative financing arrangements

Key discussion points included:

- Management reported that it has been responding to requests from Ministers to consider a framework for alternate funding arrangements. A report back to Ministers is planned for July 2023. EY

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has been providing services because Te Whatu Ora does not have the internal capability to consider the issues.

- Committee noted that we had yet to receive guidance from Cabinet; therefore, it is unclear if alternate funding models are something Te Whatu Ora can reasonably peruse.
- The Committee noted that the consultations and recommendations that EY has reached were not unexpected for Committee members.
- The Committee stated that the information provided needs to provide an appropriate rationale for how best to use different sources of capital going forward.
- The internal capacity and capability to support this work within Te Whatu Ora remains unclear
- Committee want to ensure that lessons from other Public/Private partnerships are considered, including examining a wide range of projects of size and complexity.
- Management noted that some projects are becoming urgent, including Carparking. Therefore, management supports a framework being developed to progress these issues. The committee was unclear whether this was an urgent matter needing consideration but supported exploring the opportunity for alternate funding.
- Developing an asset management plan is essential to identify priorities for investment.

The Committee agreed to:

a) **note** the contents of this report.
b) **discuss** the priority of further development of alternative financing approach and if the Infrastructure Investment Group should report back with a proposed work programme.

2.6. Waitemata District (primary birthing unit) Business Case

Key discussion points included:

- The Committee sought clarification of the accounting treatment of the lease and advice given to the Ministers as Waitemata DHB had led this project.
- The Committee expressed concern at the lack of visibility of build or operational costs. The Committee needs assurance of how costs overruns, CAPEX, plant replacement, any cap on rent and risks will be dealt with by both parties. **Action:** Management to redraft the paper to it clearly expresses both parties' expectations to assure that this project's funding and delivery will be appropriate.
- Management confirmed Ministers had not confirmed funding arrangements.
- Committee noted this arrangement proposed using alternative financing arrangements and noted that this is a small asset to be funding when taking a national portfolio view.
- The Committee did not want to delay the project but needed more information to make a robust decision

The Committee agreed to:

a) **note** that the Ministers of Health and of Finance approval is required for Te Whatu Ora to enter into the lease agreement proposed for the Waitākere Primary Birthing Unit pursuant to section 99 of the Pae Ora (Healthy Futures) Act 2022.
b) **note** that this paper has been shared with Te Aka Whai Ora | Māori Health Authority Board.
c) **note** the interdependency of this case with the Committees direction on further work regarding alternative financing arrangements for Health infrastructure.

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d) **note** the cooperative agreement between Te Whatu Ora and the Well Foundation will require a funding source to be allocated and the potential commitment of capital funding to support the finance arrangements.
e) **recommend** that the project is picked up by the National team who continue with due diligence and report back to Committee noting Ministerial approval can be sought in the New Year.

2.7. Counties Manukau Health Park Vector Easement

Committee agreed it is an operational matter and will be dealt with by Management.

3. Discussion Papers

3.1. Asset Work programme

Key discussion points included:
- The Committee provided feedback that management set realistic and achievable objectives.
- Committee recommended that management develop constraints register embedded into our projects to gain better insights into the Asset work programme.
- The committee supported the public release of this document once complete to provide this information to the public and Ministers.
- The committee requested a wider lens of capital assets be considered, including how the reform will alter how we manage assets and new approaches that will drive down investment in physical assets.

The Committee agreed to:
a) **note** the requirement for Te Whatu Ora to have an asset management framework and the work programmes currently under way to support the development of the framework.
b) **provide** any feedback as appropriate or place this paper on the agenda for further discussion in January 2023.

3.2. MBIE Construction Sector Accord-Review of Construction Contracts

The Committee agreed to:
a) **note** the MBIE Construction Sector Accord's (the Accord) specific recommendations to Te Whatu Ora which seeks Chief Executive approval.
b) **note** the response from Te Whatu Ora to the Accord's recommendations supports making construction contracts more consistent, transparent and fair across state sector entities.
c) **note** this is a discussion only paper for the Capital and Infrastructure Committee and is not intended to be shared with Te Aka Whai Ora | Māori Health Authority Board.

4. Standing items

4.1. Health Capital project and Rapid Hospital Improvement Programme update

Key discussion points included:
- The Committee supported sharing the report with Te Aka Whai Ora when the Committee receives it.
- The Committee asked management to pick up and communicate the projects which are being completed.

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- Management is exploring the cadence of meetings and reporting to ensure it better aligns with Board and Minister reporting requirements. Also, looking at what detail is required to provide assurance and oversight. **Action:** The Chair and CE will pick up with Minister to ensure the information provided meets the Minister's needs.
- **Action:** Committee requested narrative is added to the report to provide insights into the risks and issues for governors.
- The committee wanted to avoid seeing reporting on the amount of money being spent as a demonstration of activity. Instead, it requested management focus on investment outcomes.

The Committee agreed to:

a) **receive** HNZ00006801 Update on Health Capital Projects – December 2022 and HNZ00006802 Rapid Hospital Improvement Programme: October 2022 Status Report (and all the appendices).
b) **note** that the Minister of Health and Minister of Finance (Joint Ministers) have received these reports so they can be discussed at the monthly 'Health Check-Up' meeting on 9 November.
c) **note** that these reports have also been provided to the Ministry of Health in their monitoring capacity.
d) **recommend** the appropriate channel and timing to share this reporting with Te Aka Whai Ora.

4.2. Forward Committee Plan

Item was noted without discussion. Committee noted the January meeting would be used to set direction for 2023 and work plan priorities.

4.3. Key risks and issues

Item was noted without discussion.

4.4. Other business

Seismic work programme: Management reported that two further buildings had been identified as having low seismic ratings. These are the main ward building at Waikato Hospital and Wellington Hospital Link building. Management is meeting with local staff and ensuring they are supported and understand they are not working in an unsafe building.

The Committee noted that it is expected that the seismic work programme will uncover more buildings.
Action: The Committee requested that it be provided with a written update on these matters and updated on developments.
Action: The committee requested management ensure the Minister's office is aware of these matters.

5. Whakamutunga

The meeting closed at 10.35am

6. Karakia

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Te Aka Whai Ora
Māori Health Authority

Te Pae Tata | Interim New Zealand Health Plan

2022

E kore tēnei whakaoranga e huri ki tua o aku mokopuna

Our mokopuna shall inherit a better place than I inherited

This is the first New Zealand Health Plan published under the Pae Ora legislation. It is an interim plan for the first two years of operation for Te Whatu Ora – Health New Zealand and Te Aka Whai Ora – Māori Health Authority. This interim plan takes significant steps in priority areas to build our future health system, and to improve health outcomes and equity amongst New Zealanders.

The first comprehensive plan under the Pae Ora (Healthy Futures) Act 2022 will be prepared for delivery in early 2024.

Foreword

As we set off on our journey to Pae Ora,
I am reminded of the Tongikura of Kiingi Tāwhiao,

"E kore tēnei whakaoranga e huri ki tua o aku mokopuna – Our mokopuna shall inherit a better place than I inherited".

We will work collaboratively and collectively with Te Whatu Ora to ensure we drive through system changes, and grow and develop Te Ao Māori solutions, by supporting and enabling the development of our Māori providers, and increasing a sustainable and fit for purpose workforce, whilst ensuring whānau voice and local community solutions are well understood and embedded.

Te Tiriti partnership will be reflected at every level and through every phase of the reforms. Our pro-equity approach will be our anchoring guide from Te Pae Tata to Pae Ora.

Tipa Mahuta
(Waikato, Maniapoto, Ngāpuhi)
Board Chair, Te Aka Whai Ora

Foreword

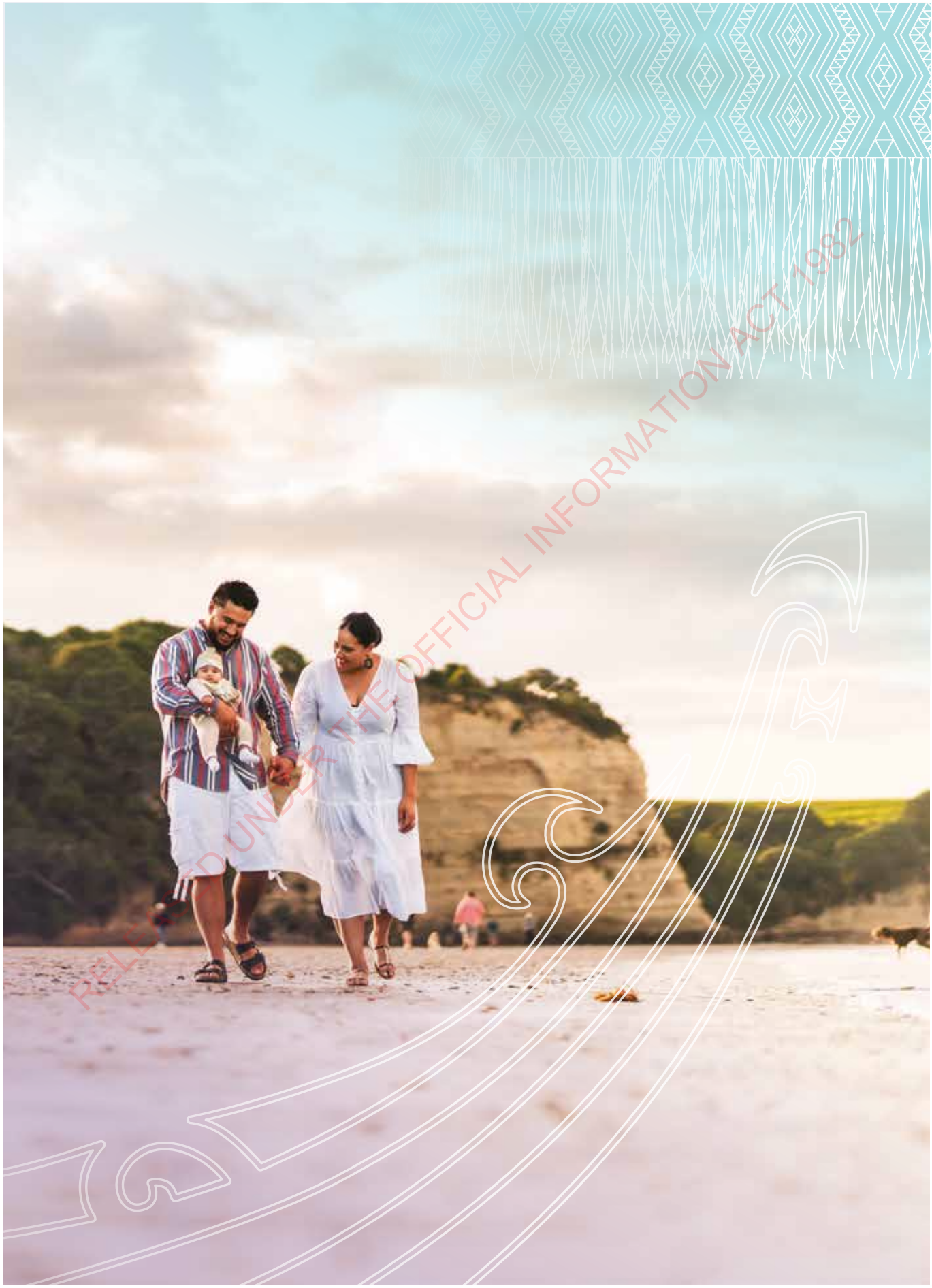
Te Pae Tata is a staging post on the journey to Pae Ora. While this is an interim document that will evolve in future iterations, it marks a new level of transparency and accountability for the health system. Our structure and planned activities and reporting within Te Whatu Ora are based around delivery of Te Pae Tata.

Working together with Te Aka Whai Ora, we place equity and excellence, efficiency and effectiveness at the forefront of all of our delivered and funded services. We also foster innovation and energy in the same cause.

This is our health system, it belongs to all of us and serves all of us. We each have both common and specific needs, and this unity and diversity must be built into how we think, speak and act. This goes for all working within and with the health system.

Te Pae Tata has a wide range of actions – that is the nature of a national health service in a diverse society. We cannot avoid complexity and cost. But we can cut through bureaucracy and duplication and waste. We can be clear and decisive. Nothing else will do.

Rob Campbell
Board Chair, Te Whatu Ora



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Appendices

Introduction

Te Whatu Ora – Health New Zealand and Te Aka Whai Ora – Māori Health Authority present Te Pae Tata: interim New Zealand Health Plan.

This is an initial plan only, designed to get us up and running while a full process can be undertaken to design the first full scale New Zealand Health Plan. It replaces 20 different district annual plans. Through its implementation, it establishes a national service coverage and operating policies to unify our operating environment. It does not reflect everything that we will be doing over the next two years but lays out a foundational set of actions towards our goals. Te Whatu Ora and Te Aka Whai Ora have jointly created Te Pae Tata and acknowledge the stewardship and support of the Ministry of Health.

This is a period of reset, changing the foundations of our health service delivery system. Te Pae Tata delivers on the expectations of the interim Government Policy Statement on Health, the expectations of the Pae Ora legislation and the five key shifts, creating a new health service delivery system to serve all New Zealanders. Appendix two aligns the actions to these expectations.

Our new health system

The foundations of our new health system, outlined in the Pae Ora legislation are: to improve equitable health outcomes, embed Te Tiriti, implement a population health approach, and ensure a sustainable and affordable health system. Te Pae Tata outlines the first steps in becoming a health service delivery system that acts on the needs and experiences of our whānau and communities, preventing illness and supporting good health and wellbeing for all New Zealanders, no matter who you are and where you live. For Māori particularly we will embed Te Tiriti o Waitangi by growing Māori leadership, workforce and services. We are also taking action to make better financial and corporate choices so that more of our resources are in our communities and in services, rather than in corporate support.

Health equity matters for everyone: We aspire to health service delivery that gives all New Zealanders the opportunity to achieve good health and wellbeing outcomes, regardless of who they are or where they live.

Embedding a Tiriti-dynamic health system: To meet our obligations as Crown agents, we are building a health system that embeds Te Tiriti o Waitangi as its foundation. This means placing Te Tiriti at the forefront of thinking and providing opportunities to enact Te Tiriti principles and articles to improve health outcomes for Māori.

Implementing a population health approach: A population health approach, shifts our system to prevent illness and improve the health and wellbeing of local communities. We recognise that people's health can be achieved by collaboration with communities working together to plan, design and deliver health services.

Ensuring a sustainable health service delivery system: A sustainable and affordable health system will have an operating model that reduces bureaucracy and duplication as 26 entities are merged into Te Whatu Ora. It will act to innovate and redesign how we deliver care, including digital technologies to ensure health service investments contribute the greatest value.

Operating differently

Through the passing of the Pae Ora (Healthy Futures) Act 2022 and significant investment in the health sector through Budget 22, the government has created the necessary foundations for transformation of our system. To transform health service delivery in our communities, we will do more than change what we do; we are changing how we operate the health service delivery system to make the best use of resources to deliver the greatest value and achieve better and equitable health outcomes. The benefits of becoming one system, will take time to be realised but the changes we start in this interim Plan build a momentum where working as one system, with our workforces, our providers and our partner agencies becomes the platform for innovation, changes and excellence.

Through the establishment of Te Whatu Ora and Te Aka Whai Ora, and the implementation of Te Pae Tata, we will:

- **Create one system of care** with a network of both publicly and privately owned, and publicly funded healthcare providers to deliver joined-up and integrated care that people and whānau want and need.
- **Create a platform for innovation and change** that supports more equitable and better health and wellbeing for people, whānau and communities, as well as making it easier for our workforce and our providers to do their work.
- **Collaborate with our workforces** and their representatives, including unions, professional bodies, education institutions and training organisations, to grow and support our workforce, both rural and urban, to deliver what is needed.
- **Support our communities** by partnering in localities with Iwi Māori Partnership Boards, the Public Health Agency, National Public Health Service, government agencies and local government to build healthy environments that enable people to thrive.
- **Work collaboratively** across departmental agencies and Crown entities in the health sector, including Whaikaha – Ministry of Disabled People, Te Aho o Te Kahu – Cancer Control Agency, the New Zealand Blood Service, ACC, Pharmac, the Health Quality & Safety Commission and the Health Research Council. We will recognise the leadership of Te Hiringa Mahara – Mental Health and Wellbeing Commission working group, and the Health and Disability Commissioner and the opportunities this presents for improvements in our health service delivery system.

We will deliver on the reform

Government has outlined, in the interim Government Policy Statement on Health, what it expects the health system to deliver and achieve over the next two years. Alongside this, Government has prioritised five key shifts to be delivered by Te Whatu Ora and Te Aka Whai Ora.

There are four sections in Te Pae Tata: People and whānau at the heart of health; Priorities for improving health outcomes and equity; A unified, smarter, sustainable and equity-led health system and Priority populations. The broad range of actions are required to establish the foundations, implement Government priorities and deliver health services across Aotearoa.

Our six priority actions

Below we outline the core actions that create the backbone for success responding to the interim Government Policy Statement on Health and delivering on the Government commitment to five key shifts:

1. **Place whānau at the heart of the system to improve equity and outcomes**
   a. Implement mechanisms that ensure Te Whatu Ora and Te Aka Whai Ora value the voices of consumers and whānau in all service design and improvements, including Māori, Pacific, Tāngata whaikaha | Disabled people, ethnic and rainbow communities.
   b. Improve equity and outcomes by implementing service change and innovation in five priority areas:
      i. **Pae ora** | Better health in our communities
      ii. **Kahu Taurima** | Maternity and early years
      iii. **Mate pukupuku** | People with cancer
      iv. **Māuiuitanga taumaha** | People living with chronic health conditions
      v. **Oranga hinengaro** | People living with mental distress, illness and addictions
   c. Implement the Pacific health plan priorities.
   d. Implement the Health of Tāngata whaikaha | Disabled people plan priorities.

2. **Embed Te Tiriti o Waitangi across the health sector**
   a. Embed the principles and obligations of Te Tiriti o Waitangi and implement the Māori health improvement plan.

3. **Develop an inclusive health workforce**
   a. Grow the numbers and diversity of the health workforce, including Māori, Pacific and Tāngata whaikaha | Disabled people, to meet demand by addressing critical workforce gaps and ensuring workforce pipelines for future growth.
   b. Implement Te Mauri o Rongo | the Health Charter, and monitor actions to improve the workplace experience of the healthcare workforce.
   c. Develop an inclusive leadership and culture increasing the number of Māori, Pacific and Tāngata whaikaha | Disabled people in leadership and decision-making roles across the system.

4. **Keep people well in their communities**
   a. Implement the localities model across Aotearoa with locality partnership groups and provider networks to ensure all New Zealanders are part of a locality, with published plans agreed with Iwi Māori Partnership Boards.
   b. Establish the National Public Health Service, embedding Te Tiriti and leading implementation of a population health approach across service commissioning and localities, including working with Iwi Māori Partnership Boards.
   c. Establish comprehensive primary and community care teams within locality provider networks and improve access to healthcare for rural and remote communities.
   d. Implement the Reset and Restore Planned Care Plan with demand balanced across sites to maximise delivery to all our communities, utilising all the resources available.

5. **Develop greater use of digital services to provide more care in homes and communities**
   a. Scale and adapt population health digital services developed to support the COVID-19 response to serve other key population health priorities.
   b. Improve the interoperability of data and digital systems across the hospital network, and between primary, community and secondary care settings.
   c. Improve digital access to primary care as an option to improve access and choice, including virtual after-hours and telehealth, with a focus on rural communities.

6. **Establish Te Whatu Ora and Te Aka Whai Ora to support a financially sustainable system**
   a. Implement a new national, regional and local organisation structure that unifies and simplifies the system including a consistent standardised operating model for corporate functions, including people and culture, finance, commissioning, hospital and specialist, data and digital and infrastructure.
   b. Capture the efficiencies of consolidation to redirect resources to the delivery of healthcare with an emphasis on reducing the overall proportion of expenditure related to corporate costs, redeploying those savings to frontline staff and services.
   c. Create and implement actions to deliver national consistency in data and digital capability and solutions across Te Whatu Ora including streamlining duplicate legacy systems inherited from DHBs and Shared Service Agencies, to improve intra-operability and reduce operating costs.
   d. Deliver the approved capital projects that are underway, to ensure that project milestones are met, and benefits realised.

e. Deliver a national asset management strategy and capital investment plan to inform Budget 2024, and out years, including the information solution strategy, requirements and road map for asset management and investment analysis.
f. Build the national procurement and supply chain function that implements supply chain strategy, policies, and guidance.
g. Implement a climate sustainability and response plan across the health sector.

Performance accountability

Te Pae Tata has a broad range of actions, and Te Whatu Ora and Te Aka Whai Ora must build the confidence of the Government, providers, the workforce and New Zealanders that the reform is making affordable decisions and having the impact needed. We are integrating the platforms and performance measurement systems of 26 agencies starting with maintaining current performance measurement systems.

In these first two years, we begin with the existing performance measures, including those in the interim Government Policy Statement on Health. We will report against the achievement of the actions outlined in this plan and on our national and regional financial performance.

From 1 January 2023, we will have new system performance improvement measures. These measures will start to demonstrate what New Zealanders can expect from our system.

Finally, the affordability of these changes is underpinned by financial planning. Government is supporting this transition with a two-year funding pathway providing the necessary financial certainty for our first two years of operation.

In Te Pae Tata all the actions are:

- directly funded as an initiative in Budget 22; or
- funded by a previous budget decision where the revenue has transferred to Te Whatu Ora from the Ministry of Health; or
- funded by the consolidation of existing resources; or
- funded by the re-commissioning, meaning redesign and re-contracting, of existing services.

Delivering on Government's expectations

Te Pae Tata is about delivering on the Reform.

Te Pae Tata delivers on the five key shifts with actions that will ensure the intentions of Government are reflected in the achievements of Te Aka Whai Ora and Te Whatu Ora:

The health system will reinforce Te Tiriti principles and obligations: By committing to the principles and obligations of Te Tiriti, adopting learnings and making the service changes that improve equity of access and outcome for Māori. This includes expanding Te Ao Māori health services.

All people will be able to access a comprehensive range of support in their local communities to help them stay well: Strategies include introducing a locality approach across Aotearoa, establishing comprehensive primary and community care teams, and increasing the range of Te Ao Māori and Pacific-led services in communities. It also means ensuring the needs of Tāngata whaikaha | Disabled people are included in service development.

Everyone will have equitable access to high quality emergency and specialist care when they need it, wherever they live: By establishing inclusive leadership and networks that drive equitable access regionally and nationally. This includes ensuring the system is consistent and people can access the care they need from the hospital networks, through ambulance and air transport, and through telehealth consultations.

Digital services will provide more people with the care they need in their homes and communities: Through expansion of telehealth access for primary care and specialist services, especially for those who cannot and do not access these services now. A national approach to digital solutions will be adopted to improve the capacity of services for digitally-enabled service delivery, to increase digital access options and improve digital literacy.

Health and care workers will be valued and well-trained for the future health system: This includes growing our workforce, driving urgent solutions to increase Māori and Pacific participation, and starting to resolve the workforce pipeline challenges, such as for doctors, nurses and midwives. We will work out how to employ a more professionally-diverse workforce, ensuring a wide range of multidisciplinary and unregulated roles are supported in teams.

Te Pae Tata delivers on the interim GPS with actions that will ensure the intentions of Government are reflected in the achievements of Te Aka Whai Ora and Te Whatu Ora.

Achieving equity in health outcomes: Establishing actions that ensure that equity in access and outcomes is a critical change in Te Pae Tata. Our approach to equity includes ensuring inclusive leadership, embedding equity in digital innovations and service redesign, and the removal of barriers to equity by growing Te Ao Māori and Pacific service delivery models and ensuring accessibility for Tāngata whaikaha | Disabled people.

Embedding Te Tiriti o Waitangi across the health sector: Te Pae Tata has been developed jointly by Te Whatu Ora and Te Aka Whai Ora. It embeds support for the Iwi Māori Partnership Boards, grows Māori leadership and develops services informed by mātauranga Māori. It also embeds actions to create a culturally safe workforce and ensure accountability across the system for equity of access and outcome for Māori.

Keeping people well in their communities: Te Pae Tata takes action to ensure communities can access a comprehensive range of support through a range of services and support locally to help people and whānau stay well. Actions include introducing a locality approach across Aotearoa, establishing comprehensive primary and community care teams, increasing the range of Te Ao Māori and Pacific-led services in communities and expanding digital technologies. Reducing variation to improve equity of service access and outcomes to planned and urgent specialist and hospital services. This includes ensuring the system is consistent and people can access the care they need from the hospital networks, through ambulance and air transport, and digital health care.

Developing the health workforce of the future: Te Pae Tata takes action to grow, strengthen and value our workforce. This includes driving urgent solutions to grow our workforce, increase Māori and Pacific participation, and starting to resolve the workforce pipeline challenges. It includes actions that will enable us to employ a more professionally-diverse workforce, ensuring a wide range of multi-disciplinary and unregulated roles across the health system.

Ensuring a financially sustainable health sector: Te Pae Tata will simplify the organisation of health service delivery. In this first year, the focus will be on merging the 20 district health boards and their seven shared service agencies into a single entity with a single operating model. We will take actions to unify and simplify the systems of decision making; nationalising enablers including procurement, data and digital systems, long term planning, infrastructure investment choices and workforce planning. It also reduces duplication and concentrates resources to achieve improvement in outcome and equity across priority areas of health service delivery.