Te Whatu Ora
Health New Zealand

Briefing

Update on New Dunedin Hospital

Date Due:	15 December 2023	**Priority:**	Urgent
Security level:	In Confidence	**Reference:**	HNZ00034728
To:	Hon Dr Shane Reti, Minister of Health		
From:	Jeremy Holman, Chief Infrastructure and Investment Officer		
Copy to:			

Minister:	**Action sought:**	**Action required by:**
Hon Dr Reti, Minister of Health	Agree to an urgent briefing with the Minister of Finance, and potentially the Minister of Infrastructure, to update them on the cost pressures associated with the New Dunedin Hospital project and seek direction on preferred course of action.	18 December 2023

Contact for discussion			
Name	**Position**	**Phone**	**1st contact**
Monique Fouwler	Interim Head of Infrastructure Delivery, Infrastructure and Investment Group	s9(2)(a)	X
Jeremy Holman	Chief Infrastructure and Investment Officer, Infrastructure and Investment Group	s9(2)(a)	

The following departments/agencies have been consulted:
Te Waihanga The Treasury

Minister's office to complete

☐ Approved ☐ Declined

☐ Noted ☐ Needs change

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☐ Seen ☐ Overtaken by Events

☐ See Minister's Comments ☐ Withdrawn

Comments:

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Purpose

1. This briefing provides you with information on the New Dunedin Hospital (NDH) project and seeks your agreement to urgently brief the Minister of Finance, and potentially the Minister for Infrastructure, and seek direction on preferred course of action.

Recommendations

Te Whatu Ora recommends that you:

	Minister Reti
a) **Agree** to an urgent briefing with the Minister of Finance, and potentially the Minister of Infrastructure, to update them on the cost pressures associated with the NDH project and seek direction on preferred course of action.	Yes / No
b) **Note** that the NDH project is at a milestone that requires a decision to proceed or not.	Noted
c) **Note** that there are risks and issues with either proceeding or revisiting the project.	Noted

9(2)(a)

Hon Dr Shane Reti, Minister of Health

Date:

Jeremy Holman

Chief Infrastructure and Investment Officer
Infrastructure and Investment Group
Te Whatu Ora – Health New Zealand
Date:

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Summary

2. The NDH project is at a critical milestone where, under normal circumstances, a construction contract for the Inpatient Building would be entered into. However, due to legacy decisions, known cost pressures and additional works that were not included in the business case, the current estimated cost to complete the project is s9(2)(f)(iv), s9(2)(b)(ii) and s9(2)(j) above the current NDH appropriation and tagged contingency.
3. We are seeking a direction from the Government on whether:
    a. There is support for continuing the project on the same scope and scale and the associated additional funding that is required to support that approach; or
    b. Pausing the project in totality and undertaking a review of the scope and scale to confirm that it provides the best health outcomes for the people of the region.
4. We seek an urgent meeting with yourself, the Minister of Finance, and potentially the Minister of Infrastructure, to discuss the risks that have been transferred to Te Whatu Ora because of legacy decisions and seek direction on the preferred course of action.

Background

5. The Detailed Business Case for NDH included three critical dependencies that are required to ensure that system-wide benefits are achieved from this project. These critical dependencies are:
    a. A Primary and Community Care Strategy and Action Plan, ensuring the objective of reducing medical admissions is achieved.
    b. A digital blueprint and programme of investment that supports efficiencies in treating patients in the right place, at the right time, as well as continuing improvements in staff productivity.
    c. A Workforce Strategy and Action Plan, to ensure that all clinicians work to the top of their scope, deliver care in the right place and support implementation of new models of care.
6. The NDH project is made up of two buildings: the Outpatient building and the Inpatient Building. The Outpatient building is under construction, with steel framing going up now. The Inpatient building is ready to begin the main construction.
7. The current appropriation for NDH is $1.59 billion for the building of the facility alone. There is also a Budget 22 tagged contingency of $225 million ($64 million opex and $161 million capex) for the data and digital component. s9(2)(g)(i), 9(2)(j)
8. Including the data and digital budget, a new pathology laboratory (~$45 million) and inflationary pressures (~$170 million), the current capital cost estimate is ~ $2.03 billion.

9. Other costs (~$300 million) associated with the refurbishment or decommissioning of the current hospital, and any additional carparking that may be required, need to be considered. These could result in a total capital project budget well above the current estimated capital budget requirement. The final project capital budget could be circa s9(2)(f)(iv), s9(2)(b)(ii) and s9(2)(i)

10. s9(2)(g)(i)

Discussion

Legacy decisions have not set the NDH project up for success.

11. The NDH project is the largest vertical infrastructure project in New Zealand at the current time. It has been plagued with scope, budget, and programme issues since its inception because of poor planning, poor governance decisions and any real understanding of the risks associated with this project. A brief history of key decisions is attached at Appendix 1.

12. The issues resulting from those poor decisions include, but are not limited to:

    a. **Site selection** - extraordinary cost premiums associated with land purchase and demolition costs, contaminated ground, archaeological surveys /excavations, piling difficulty, flood level risk, water table depth and access issues due to it being built on a traffic island in the middle of State Highway 1. The alternative location at Wakari Campus, using the spare land available would have saved significant money.

    b. **Building footprint** – the decision to build initially three, now reset to two buildings, rather than one, has significantly increased the complexity and cost of development.

    c. **Fast Track programme** - s9(2)(g)(i)

    d. s9(2)(b)(ii), 9(2)(j), 9(2)(g)(i)

14. These legacy decisions have led to significant risk being transferred to Te Whatu Ora. To manage that risk, s9(2)(a), 9(2)(g)(i) , implemented improved Governance, reset the design down to two buildings (instead of three), supported the cancellation of the Interprofessional Learning Centre, and taken $90 million of costs out through a design reset.

Ongoing cost pressures will require additional funding.

15. The current appropriation for NDH is $1.59 billion for the building of the facility alone, plus there is a Budget 22 tagged contingency of $225 million ($64 million opex and $161 million capex) for the data and digital component. s9(2)(b)(ii), 9(2)(j)

16. The project has already seen significant cost pressures with $110 million being added to the budget in 2022. The pricing on the Outpatient Building has resulted in further cost pressures on the overall budget. The current estimated additional budget that may be required is ~$170 million. However, the final outturn costs for the project will not be known in advance of entering into the construction contract, given the commercial model being proposed.

17. Including the data and digital budget, pathology (~$45m) and cost pressures, the current cost estimate for the whole NDH project is ~ $2.03 billion. Further yet to be confirmed costs associated with the refurbishment/decommissioning of the current hospital and any additional carparking that may be required, need to be considered. This could result in a total project budget well above the current estimated budget requirement, circa $200 - $300 million.

18. The further unknown capital costs were not considered in the original planning and budget and were expected to be funded by the Southern District Health Board, even though the DHB had no money to fund these projects.

19. s9(2)(b)(ii), 9(2)(j)

20. s9(2)(b)(ii), 9(2)(j)

21. s9(2)(g)(i)

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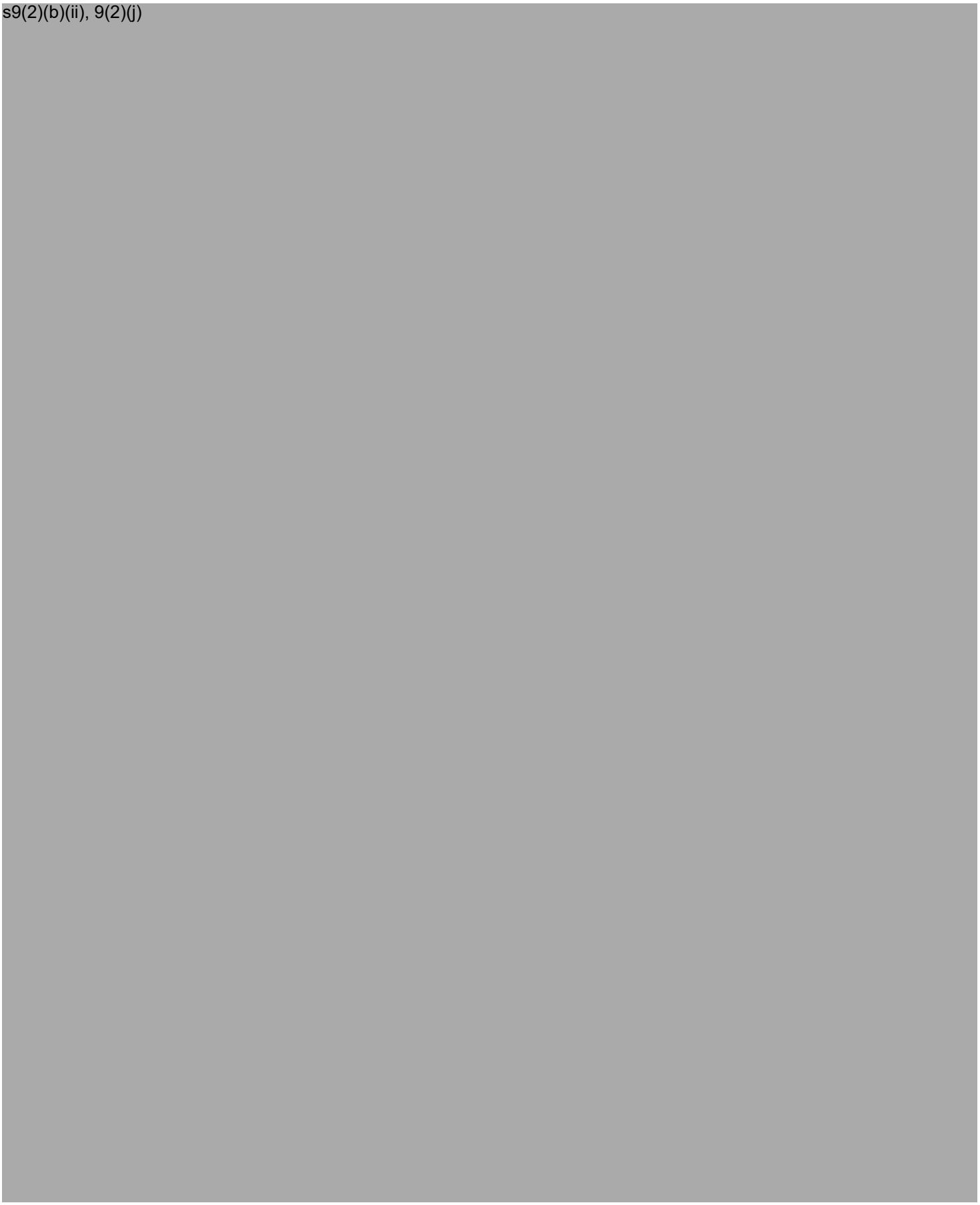
s9(2)(b)(ii), 9(2)(j)



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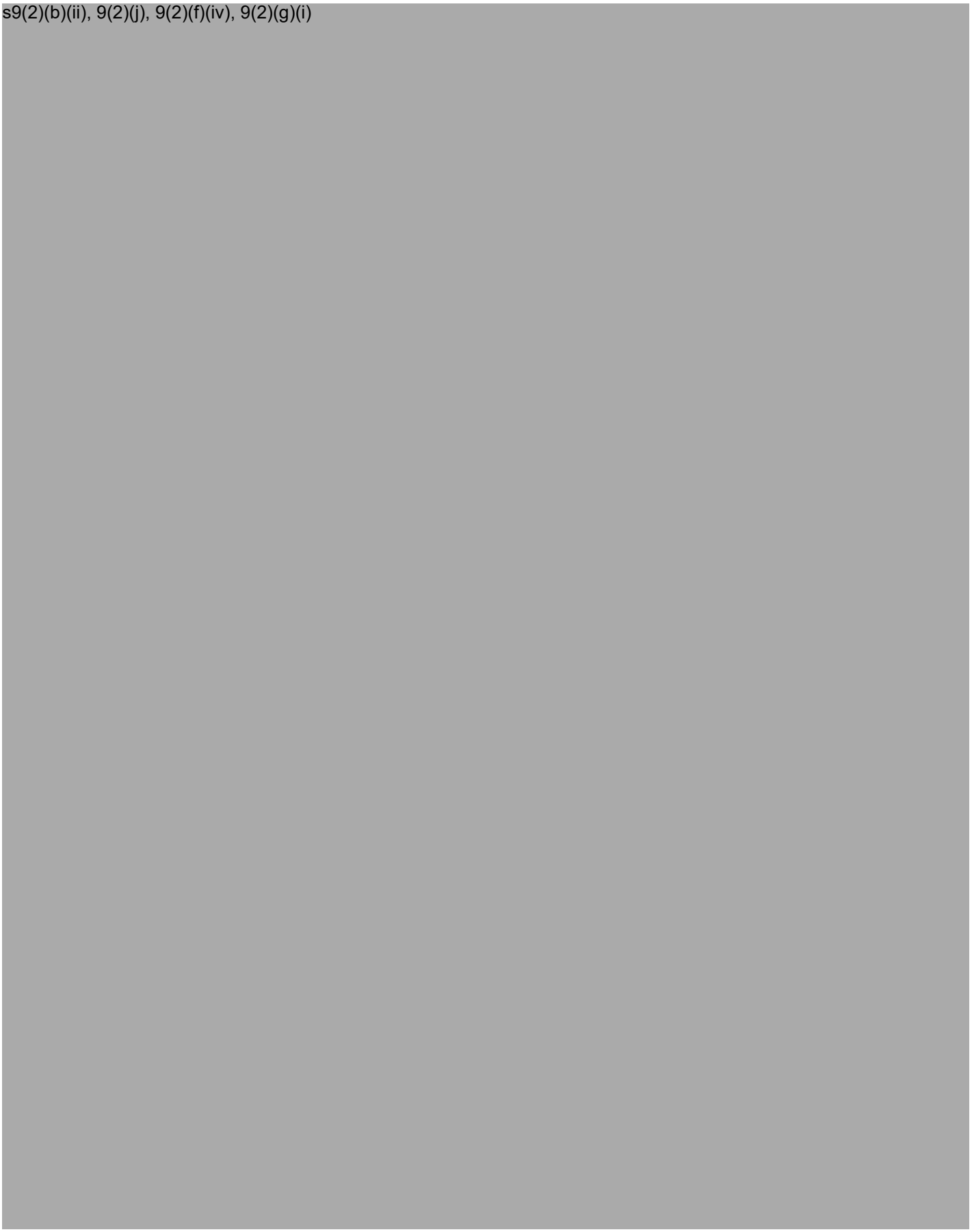
s9(2)(b)(ii), 9(2)(j), 9(2)(f)(iv), 9(2)(g)(i)



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

s9(2)(f)(iv), 9(2)(g)(i) [redacted]

34. s9(2)(f)(iv), 9(2)(g)(i)

Te Tiriti o Waitangi

35. Aside from the risk of delaying the delivery of improved health services to the southern region, there are no implications for the Crown's obligations under Te Tiriti.

Financial implications

36. Options in relation to the availability of additional capital funding for the NDH project will need to be provided by the Treasury, which could include new capital or reprioritisation of the Health Capital Envelope.

37. If the Government agrees to continue with current scope and scale and to minimize programme delays and further escalation, an agreement in principle that future funding will be made available would be required.

Next Steps

38. If you agree to a briefing to the Minister of Finance and Minister of Infrastructure a more detailed briefing will be provided.

Appendices

- Appendix 1: History of decisions made on NDH

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Appendix 1: History of decisions made on NDH

Date	Decision	Budget
July 2017	Indicative Business Case approved by Cabinet. Cabinet approved a greenfield redevelopment of core Dunedin Hospital buildings on either a new site or the Southern DHB owned Wakari site at an estimated cost of $1.2 billion to $1.4 billion.	$1.2 billion - $1.4 billion
November 2018	Cadbury Factory site purchased.	
April 2021 [CAB-21-MIN-0124]	Detailed Business Case approved by Cabinet agreeing to new site in Dunedin CBD.	$1.47 billion
February 2021	New Governance of the New Dunedin Hospital put in place resulting from a Gateway Review recommendation.	
March 2022 [HR20220041]	Due to cost pressures estimated at $200 million from scope creep and inflationary pressures from COVID-19, Joint Ministers agreed to a series of cost saving measures that equated to $89 million, with an additional funding requirement of $111 million being recognised as a pressure against the Budget 22 appropriation. Joint Ministers noted that any further significant deviations from what has been agreed needed approval from Joint Ministers.	$1.47 billion
s9(2)(a, 9(2)(g)(i)	[redacted]	
December 2022 [HNZ00008490]	Joint Ministers agreed to value management savings of $90 million and released the Budget 22 provision of $110 million.	$1.58 billion
January 2023	Enhanced Project Governance implemented in line with Te Waihanga advice.	
April 2023 [HNZ00015667]	Joint Ministers agreed to $10 million additional funding to cover the cost of: • A completion of the review of the pathology services. • A review into mental health services for older people capacity to ensure that the capacity provided is appropriate into the future. • The purchase of an MRI machine. • Fit out of shelled collaborative spaces.	$1.59 billion
June 2023 [HNZ00019210]	The Ministers of Health, Finance and Education agreed that while Interprofessional Learning remains a priority, building a new Interprofessional Learning Centre (ILC) was no longer financially feasible nor a priority. This was due to budget constraints and cost pressures being experienced	Estimated costs for the ILC were estimated to exceed $140 million, making each parties share >$50 million. The amount budgeted for

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Date	Decision	Budget
	by Te Whatu Ora, Te Pūkenga and the University of Otago.	the ILC in the NDH project budget was $17 million.
May 2023 [HNZ00029011]	The pathology review recommended that a new 4000m2 building incorporating an integrated hospital and community pathology lab was the most efficient method of delivering pathology services. Initial cost estimates of this option were around $45 million. However, no location for this building has been identified and no funding is available. If adopted, it may be that the pathology service provider or other private sector developer could undertake the build, but this needs further investigation.	Early estimate of cost for the provision of a stand-alone pathology building is $45 million (excluding fitout). This is not currently funded so the pathology provision will stay in the old hospital until funding is available.

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Minister's Comments

Aide-Mémoire

Additional information on New Dunedin Hospital

To:	Hon Dr Shane Reti, Minister of Health	**Reference:**	HNZ00034932
From:	Jeremy Holman, Chief Infrastructure and Investment Officer	**Due Date:**	21 December 2023
Copy to:	Minister of Finance and Minister for Infrastructure	**Security level:**	In Confidence

Contact for telephone discussion (if required)			
Name	**Position**	**Telephone**	**1st contact**
Monique Fouwler	Interim Head of Infrastructure Delivery	s9(2)(a)	
Jeremy Holman	Chief Infrastructure and Investment Officer	s9(2)(a)	X

The following departments/agencies have been consulted

Attachments	Appendix 1: Scope, scale and status of New Dunedin Hospital Appendix 2: HNZ00034728 Update on New Dunedin Hospital Appendix 3: Treasury Advice Appendix 4: Te Waihanga Advice

9(2)(a)

Jeremy Holman
Chief Infrastructure and Investment Officer
Infrastructure and Investment
Te Whatu Ora - Health New Zealand

Additional information on New Dunedin Hospital

Purpose

1. This Aide-Mémoire provides additional information relating to New Dunedin Hospital (NDH) to inform a meeting with the Minister of Finance and Minister for Infrastructure.

Meeting Details

2. Meeting details are yet to be confirmed with the Minister of Finance and Minister for Infrastructure. We recommend a meeting date is set as early as possible - preferably January 2024.

Context

3. The purpose of that meeting with Minister of Finance and Minister for Infrastructure is to update them on the cost pressures associated with the New Dunedin Hospital project and discuss direction on preferred course of action [HNZ00034728 refers].

4. s9(2)(b)(ii), 9(2)(j) [redacted]

5. This paper, as requested, elaborates on:

   - Decommissioning options to reduce costs.
   - Other costs that were not included in the scope but are material to realising the benefits of the case.
   - s9(2)(f)(iv), 9(2)(g)(i) [redacted]
   - Potential to shift services from the NDH to community, including commissioning or 'off balance' sheet approaches for delivering care.

6. We have also included advice received from the Treasury (Appendix 3) and Te Waihanga (Appendix 4) s9(2)(f)(iv), 9(2)(g)(i) [redacted]

Discussion

Scope and Scale of NDH

7. NDH is currently the largest vertical infrastructure build in New Zealand. The scope and scale of the project compared to the current hospital, along with the project status of each building, is outlined in Appendix 1.

8. NDH is also the first of several potential billion dollar plus builds replacing major hospital infrastructure in provincial regions. The approach we take to this project will lay the foundation for subsequent projects, potentially in Whangārei, Hawke's Bay and Nelson-Marlborough.

9. We are aware of costs that were excluded in the original business but may be material to realising the benefits of this case.

10. A summary of the current cost estimate is included in the table below.

Funding requirement	**Current funding**	**Required Funding (2023 $)**
NDH appropriation	$1,590 million capex	
Data and Digital tagged contingency	$225 million capex	
Cost escalation		~$170 million capex
Pathology Lab - capital		~$45 million capex
Reuse/decommissioning existing hospital, carparking		s9(2)(b)(ii), 9(2)(f)(iv)
Additional workforce		~$108 million opex
Total	**$1,815 million capex**	s9(2)(b)(ii), 9(2)(j)

Decommissioning Costs

11. The current hospital has an area of ~60,000 square metres.

12. There are several services occupying approximately 24,500 square metres sprinkled across the existing hospital buildings that are not included in the scope of the new hospital. A range of potential locations for these services – either onsite, off site adjacent or at a point distal to the hospital (e.g. a hub) – is possible. This planning has not been undertaken yet and therefore we do not know what the costs associated with these remaining services will be, nor what is to be done with the remaining buildings.

13. Some buildings will not be suitable for reuse and will need to be demolished for health and safety reasons. One building has a heritage listing and will need to be retained.

14. The current estimated cost of repurposing or reusing existing hospital buildings is $5000 - $7000 per square metre. The current estimated cost of demolishing

buildings in the city centre that are likely to include significant asbestos is $1000 - $1500 per square metre.

15. Depending on the outcome of the planning for the remaining buildings, it could cost anywhere between $100 million if everything was demolished and $450 million if all buildings were repurposed. The current untested estimate of between $200 - $300 million considers that some buildings will be demolished, and others will need to be repurposed.

s9(2)(f)(iv)

[redacted]

Carparking

18. Although the Resource Consent for NDH does not require parking, due to the central city location, additional carparking for staff and patients is seen as an enabler of the hospital.

19. However, market sounding that occurred in 2021 found that the private sector did not see the investment as attractive. This was due to the low cost of parking in Dunedin generally, and the amount a private investor would need to charge for parking to make a return on their investment would mean they would be pricing well above the current parking charges in Dunedin.

20. The funding to provide patient and staff parking will either then need to be funded through new Crown capital, or additional operating funding to top up the parking and make the investment more attractive to the private sector.

Possibilities for shifting services from NDH to the community.

21. The design reset, undertaken in mid-2022, where $90 million and 6,600m^2 were removed from the design of NDH, required that all services not needing to be delivered from an acute service hospital be considered for removal. Very few services were identified to be removed, except for the following three: Pathology, Food/Kitchen services and Mental health services for older people

22. Pathology has been removed from the NDH as the service, which is currently split over two sites at the existing hospital, and was intended to be replicated. Only half the pathology was to move, which has been found to be an inefficient delivery method for laboratory services. The pathology review found that the most efficient

way to deliver pathology services was for a single standalone facility twice the size of the pathology service originally planned for NDH.

23. Currently estimated at circa $45 million for a shell facility on land we own, there are options around the funding required to deliver the pathology facility. These include new Crown capital, build and lease back, or the service provider of pathology services builds the facility. Work on the business case for the pathology facility is being developed and will need to consider how Te Whatu Ora wants to procure or deliver pathology services.

24. The other two service areas, food/kitchen and mental health services for older people, would not yield significant savings as the design is so far advanced that the design fees required to remove them would be significant. Additionally, these services, if they were to be provided off-site, would still require funding, either capital to build a facility or operating to pay a third-party provider.

25. Reducing the size and scale of the hospital as currently designed (i.e. removing theatres, beds etc.), would require all construction to stop and a complete redesign to occur for both buildings, as they are currently designed to work together. This would result in significant delays, additional design costs, consideration of sunk costs and further cost escalation due to delay.

s9(2)(f)(iv), 9(2)(g)(i)

30. s9(2)(f)(iv), 9(2)(g)(i) [redacted]

Next steps

36. We look forward to attending the meeting that has been arranged early in the new year to enable further discussion and where the next steps will be made clear.

Appendix 1 – Scope, scale and status of NDH

Appendix 2 - Update on NDH Briefing HNZ00034728

Appendix 3 - Treasury Advice

Appendix 4 - Te Waihanga Advice

s9(2)(f)(iv), 9(2)(g)(i)

9. s9(2)(f)(iv), 9(2)(g)(i) [redacted]

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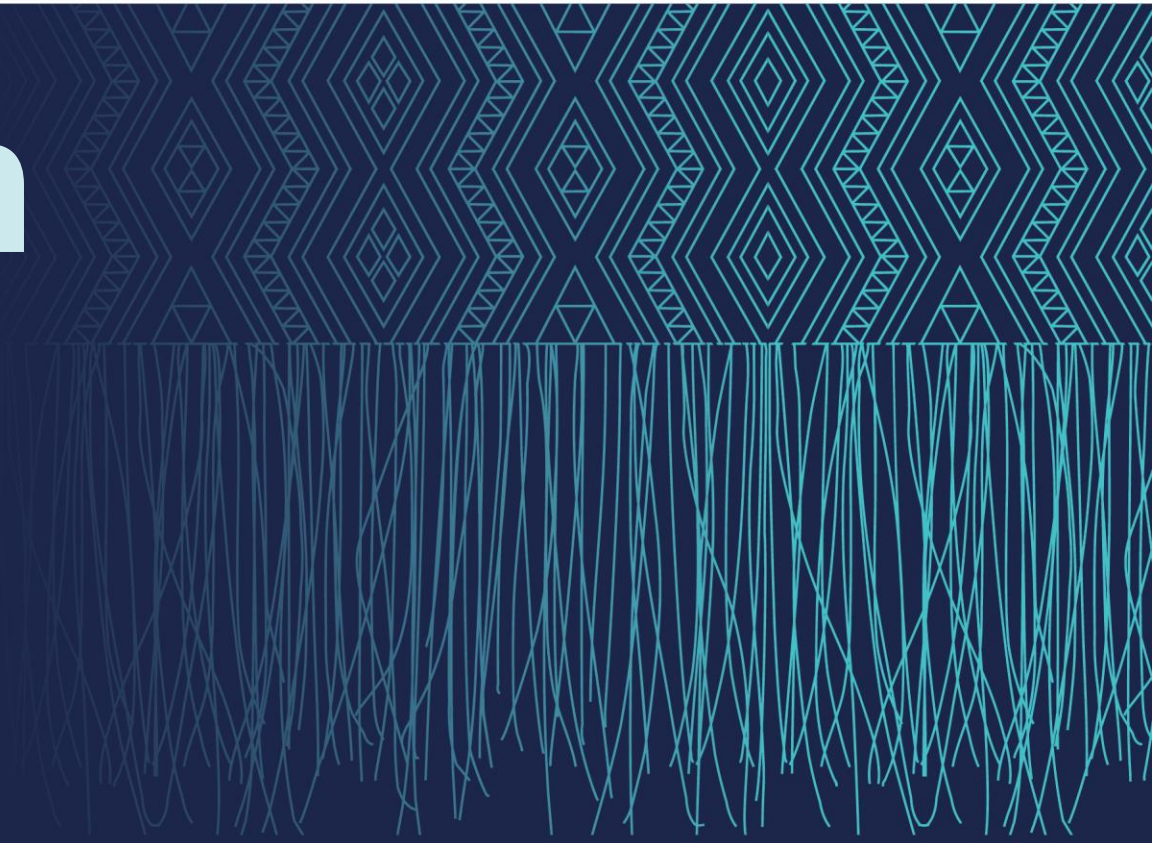
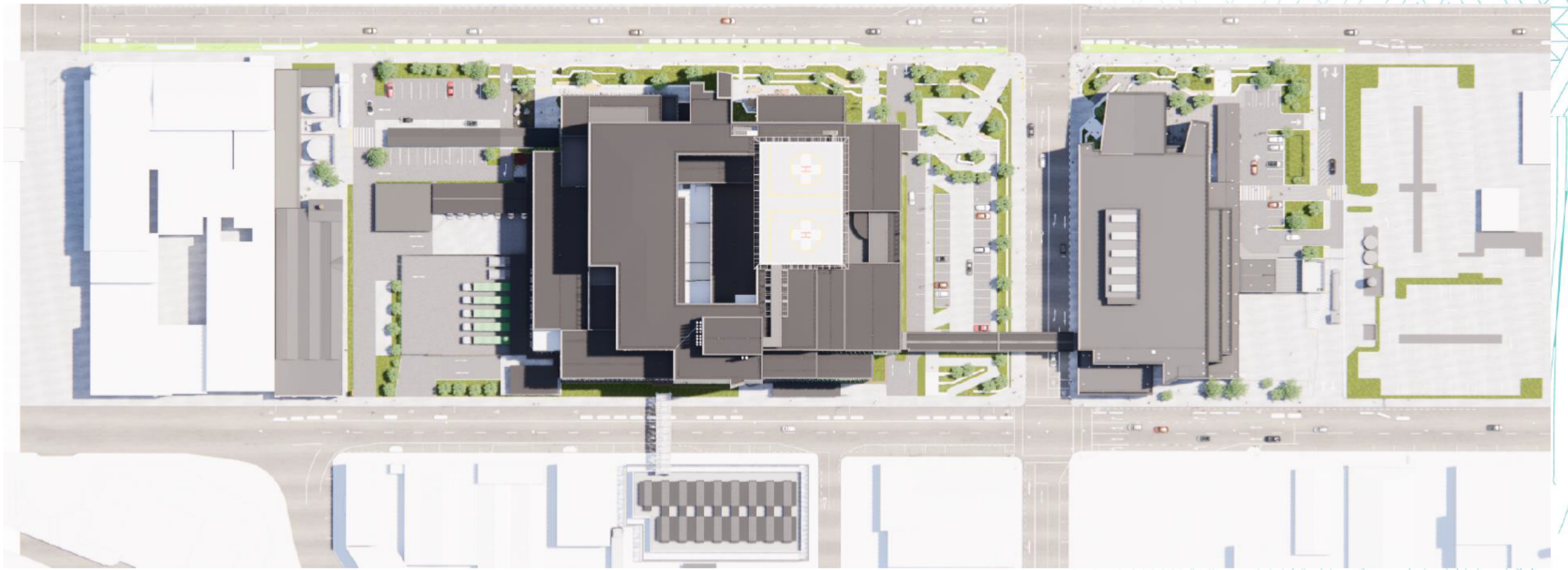
New Dunedin Hospital

Overview: December 2023



Position



Original Design

- Over budget
- Central pavilion and logistic building removed
- ~7000m2 GFA removed from the buildings
- $90m in savings made

New Design

- More compact
- Less two theatres
- 12 shelled MHSOP Beds

$1.59b

The New Dunedin Hospital is currently the largest ever infrastructure investment in health in New Zealand

It will be a modern, efficient and patient-centred teaching hospital

Stage 1
Outpatient Building

Construction has commenced and the building will include:

- **Outpatient services**
- **Clinic rooms**
- **Day Procedures Unit**
- **Planned radiology**

Stage 2
Inpatient Building

Piling for foundation has started. This building will include:

- **Expanded Emergency Department**
- **Expanded Operating Theatre Suite and short stay surgical unit**
- **Dedicated Primary Birthing Unit**
- **ICU and High Dependency beds**
- **Inpatient wards**

Our new hospital

- Modern, efficient and patient-centred teaching hospital
- Five Green Star sustainability rating
- Design and use of latest technology means greater efficiency, including patient flow around the hospital
- Better access to diagnostics and treatment spaces which helps reduce unnecessary delays
- Build gives substantial boost to Dunedin economy and unique opportunity for hundreds of locals to hone their skills on this prestigious project

Here are some comparators

Bed numbers	Theatres (includes Endoscopy and Interventional rooms)	CT, MRI & PET scanners	ED Beds	23-hour Ward
Current	Current	Current	Current	Current
367	17	5	31	0
New	New	New	New	New
410	26	9	53	20

Outpatient Building: Construction progress

August 2023
First steel column

November 2023
(view from Fire Station side)

Progressing, but delayed by seven months. Negotiations with contractor to mitigate delay underway

The smaller of the two new clinical buildings due for completion July 2026

As the steel is constructed, it will be followed by each floor being poured with concrete, then the first fix of the services

Outpatient Building

- 10,000m² Clinical Space
- State-of-the-art Day Surgery Unit
- Multi-Disciplinary Outpatient Clinics
- Radiology including MRI and CT Services
- Integrated Digital Systems
- Co-designed with Mana Whenua
- 5 Star Greenstar Rating
- Public Areas with food and retail
- Patient Drop-Off
- Inclusive and accessible for all

Artist impression – view from Cumberland Street

Inpatient Building

The larger of the two new clinical buildings

Early works, including earthworks and piling, has commenced. Foundation work is expected to commence in Q1 2024

- Completion 2029
- Expanded Emergency Department
- Operating Theatre Suite and short stay surgical unit
- Intensive care unit (ICU)
- Dedicated Primary Birthing Unit

Artist impression of the Outpatient Building (left) and Inpatient Building (right) from the cnr of Cumberland and St Andrew Sts

Inpatient Building: Contract

- New form of collaborative contract that has not been used by Health before
- Apportions risk equitability
- Incentivises the contractor to complete early and under cost estimate
- Passes some design risk to the contractor who is better placed to manage it.
- Provides for more collaboration and “best for project” outcomes.
- As with a Fixed Price Lump Sum model, the full cost is not known until completion – but is estimated as a “total outturn cost”.
- The contract has two phases with phase one being foundation work, procurement of long lead items and finalise detailed design to allow costing of phase two. Phase two has an ‘off ramp” if the price is above budget.
- s9(2)(b)(ii), 9(2)(j) [redacted]

Digital transformation

Everything will be right at the fingertips of those treating patients. This in turn will create a better experience for patients

Immediate and easy access to clinical information

No storage or retrieval of paper charts required

Information can be accessed simultaneously by multiple care providers

Groundwork established for a future electronic medical record (EMR) with digital workflow

On track

Game changer for clinicians

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Briefing

Options relating to the continued delivery of New Dunedin Hospital

Date due:	26 January 2024	**Priority:**	Urgent
Security classification:	In Confidence	**Reference:**	HNZ00035758
Copy to:	Hon Chris Bishop, Minister for Infrastructure		

Minister:	**Action sought:**	**Action required by:**
Hon Dr Shane Reti, Minister of Health	Agree that investment in improved health facilities in Dunedin and the wider Southern district is still required. Agree to funding the cost pressure on NDH through new Crown capital.	16 February 2024
Hon Nicola Willis, Minister of Finance	Agree that investment in improved health facilities in Dunedin and the wider Southern district is still required. Agree to funding the cost pressure on NDH through new Crown capital.	16 February 2024

Contact for discussion			
Name	**Position**	**Phone**	**1st contact**
Jeremy Holman	Chief Infrastructure and Investment Officer	s9(2)(a)	X
Fepulea'i Margie Apa	Chief Executive Officer	s9(2)(a)	

The following departments/agencies have been consulted:
The Treasury Te Waihanga | New Zealand Infrastructure Commission

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Minister's office to complete	☐ Approved	☐ Declined
	☐ Noted	☐ Needs change
	☐ Seen	☐ Overtaken by Events
	☐ See Minister's Comments	☐ Withdrawn

Comments:

Minister's office to complete	☐ Approved	☐ Declined
	☐ Noted	☐ Needs change
	☐ Seen	☐ Overtaken by Events
	☐ See Minister's Comments	☐ Withdrawn

Comments:

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Briefing

Options relating to the continued delivery of New Dunedin Hospital

Date Due:	26 January 2024	**Action required by:**	16 February 2024
Security classification:	In Confidence	**Priority:**	Urgent
To:	Hon Dr Shane Reti, Minister of Health		
	Hon Nicola Willis, Minister of Finance		
Copy to	Hon Chris Bishop, Minister for Infrastructure		

Purpose

1. This briefing provides you with options as to the continued delivery of the New Dunedin Hospital (NDH) and seeks your decision to continue to fund the NDH cost pressures to ensure the NDH is able to deliver the health services outlined in the NDH business case.

Recommendations

Te Whatu Ora recommends that you:

	Minister Reti	Minister Willis
a) **Agree** that investment in improved health facilities in Dunedin and the wider Southern district is still required as per the approved business case.	Yes / No	Yes / No
b) **Agree** that the NDH project requires additional funding of $170 million to maintain current programme at the current scope and scale agreed in the business case through new Crown capital now.	Yes / No	Yes / No
c) **Agree** to fund the additional contingency cost pressure of $120 million on NDH through new Crown capital as part of B25.	Yes / No	Yes / No
d) **Agree** that revisiting the scope and scale of NDH will result in delays to the provision of improved health facilities in Dunedin and may result in increased costs.	Yes / No	Yes / No
e) **Note** the clinical risks associated with not funding the NDH and/or reprioritising the Health Capital Envelope (HCE) for other planned health projects.	Noted	Noted

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f)	s9(2)(b)(ii), 9(2)(j)	Noted	Noted

Hon Dr. Shane Reti
Minister of Health

Date:

Fepulea'i Margie Apa
Chief Executive Officer
Te Whatu Ora – Health New Zealand
Date:

Hon Nicola Willis
Minister of Finance

Date:

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Summary

2. NDH is at a critical juncture in terms of the programme. The NDH business case was set under previous capital business case settings and approval processes (Appendix 1). This past process assumed that, while the core appropriation for build was approved, to enable a fully functioning hospital as an outcome, some components were not included and left to be addressed through subsequent cases.

3. Cost risks associated with those additional components are material to ensuring a fully functioning hospital. The current NDH appropriation of $1.59 billion is, therefore, insufficient to complete the works associated with the project and deliver improved health facilities to the people of Dunedin and the wider community, as anticipated in the original business case. We have retested the original population need and bed demand assumptions and conclude that the scope is still appropriate.

4. Although $170 million is required s9(2)(b)(ii), 9(2)(j)

Items requiring capex funding	Estimated (M)	Notes
Current funding approved		
NDH appropriation	$1,590	Already appropriated - $286.6m drawn down to date
Data and Digital tagged contingency	$225	$68m appropriated for Outpatients Building, $157m remains in tagged contingency from B22
Total current funding approved	**$1,815**	
Additional funding required to complete the original business case		
s9(2)(b)(ii), 9(2)(j)		
Total additional funding required to complete the original business case	**$290**	**In order to be able to complete the NDH as per the business case**

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Items requiring capex funding	Estimated (M)	Notes
Additional funding required for items not in the original business case		
Pathology Lab – capital	$45	Alternate/Off-balance sheet options will be explored i.e., joint venture with current outsourced provider. Required 2025
Carparking	s9(2)(b)(ii), 9(2)(f)(iv)	Alternate/Off-balance sheet options will be explored to explore i.e., alternative financing. Required by 2027
Reuse/decommissioning existing hospital	$325	Alternative uses of building will be explored. Required by 2029
Total additional funding required for items not in the original business case	s9(2)(b)(ii), 9(2)(f)(iv)	
Total additional capital required		
TOTAL CAPITAL FUNDING	s9(2)(b)(ii), 9(2)(f)(iv)	
Additional workforce operating costs	~$108 opex	FY25/26 and FY28/29

5. Appendix 2 provides further detail on costs and when the funding will be required. There will also be increased operating costs that will need to be provisioned for when the NDH is operational.
6. A hierarchy of decisions are sought in relation to the Government's intentions for NDH. These are:
    a. investment in health facilities in Dunedin and the wider Southern district is still required,
    b. additional funding is required to meet the current scale and scope of the NDH,
    c. if additional funding is not available, then the scope and scale will need to be revisited to stay within the current appropriation,
    d. Support to progress with current contractor and/or return to market and face risks of time delays and cost escalations.

7. There are options to fund the cost pressures and unbudgeted scope, to enable continuation (Appendix 3). The recommended option is Option 1, the commitment of new Crown Capital.

8. s9(2)(b)(ii), 9(2)(j)

9. s9(2)(g)(i), 9(2)(f)(iv), 9(2)(j)

10. If new Crown capital is not available in whole or in part, then we will need to either source alternative funding or the scope and scale of the NDH, as currently planned, will need to be revisited to remain within the current NDH appropriation (Appendix 4). The recommended option being Option 5c, to build the health facilities differently.

11. There are risks and benefits of revisiting the scope and scale, the main risk being delay to the provision of improved health services to the wider southern district.

Background

12. Recent briefings [HNZ00034728 and HNZ00034932 refer] outlined the status of NDH following a series of legacy decisions that have resulted in significant risk and issues for the project (Appendix 1). The briefings also included:

    a. discussion on cost pressures related to the construction of the new hospital and further funding that will be required as a result, and

    b. s9(2)(b)(ii), 9(2)(j)

13. The Outpatient Building is currently under construction and groundwork (piling) has started on the Inpatient Building. The Inpatient Building foundations are fully designed and consented and can be progressed. The detailed design for the structure is almost complete and ready for consent. The remainder of the developed design is nearing completion and we will be entering Detailed Design in March/April 2024, and reflects changes to the programme against the original business case due to the design reset in 2022. This set the programme back by approximately 12 months.

14. Therefore, the estimation of costs is still based on differing degree of design completion which carries significant risk in a project of this size and complexity. Full detailed design is not expected to be complete until December 2024. Contractor pricing, under the proposed commercial model and contractor, is expected in August 2024. This will be based on the remaining design outside of foundation and structure being at 100% Developed Design. It will provide a more confident indication of total outturn costs as much of the design risk will have been eliminated.

15. This estimation of costs has been updated by our Quantity Surveyors in recent months due to trade costs for the adjacent Outpatient Building coming in higher than forecast and these rates have been applied to the Inpatient Building forecast. Additionally, there

is extension of time costs for the Outpatient Building and additional contingency required to cover any further design and construction risks for such a complex and lengthy construction programme.

16. For full transparency, the s9(2)(b)(ii) and s9(2)(b)(ii) is to cover cost increases and allow for contingency. The s9(2)(b)(ii), 9(2)(f)(iv) that may be required to complete the totality of the NDH project were not included in the approved detailed business case which was originally prepared by the Southern District Health Board and the Ministry of Health.

Discussion

17. Given where we are in the programme for the NDH, and with the potential of a change of Government priorities that favours healthcare accessed closer to communities, it is appropriate to ensure that there is support and commitment for the ongoing investment in improved health services and facilities in Dunedin and the Southern region.

18. Discussed below are options relating to the current scope and scale of the NDH, and alternative options for funding the current scope and options relating to a different scope for delivering health services in the region.

Does Dunedin and the wider southern district require improved health facilities?

19. The NDH has been designed to meet the future needs of the Dunedin and the wider southern district population out to 2043. The Dunedin population is currently 353,000 and estimated to grow at 0.4% per annum to 383,000 by 2043. This is one of the most rapidly aging populations in the country and a highly distributed rural population.

20. The NDH is the primary hospital for Dunedin City which had a population of 126,000 in 2023, with services provided to the wider district in partnership with the wider network of rural hospitals and Invercargill.

21. The NDH will provide tertiary and secondary services to support a range of health needs for neonates, infants, children, adults, and older persons. It will accommodate patients requiring access to complex assessment, diagnostic and interventional technology on a planned and unplanned basis.

22. It is a key asset for Te Waipounamu region because it is more accessible to the lower part of the South Island who face long travel times to reach services. The wider regional plan will build up diagnostic access and other data and digital options for access in rural areas but none at scale will mitigate the demand for subspecialties.

23. The Strategic Case for the NDH focussed on the condition of the existing clinical facilities as well as the projected unsustainable service demand associated with an increasing aging population.

24. The problem statements that the NDH is expected to resolve are:

    a. A deteriorating environment that is eroding quality of care, creating safety risks and potential harm, causing distress to patients and staff.

b. Inflexible and inappropriate care facilities restricting service capacity, causing delays and increasing outsourcing costs.

c. Care facilities cannot absorb innovations, preventing efficiency gains and care improvements.

25. The current design of the NDH Inpatient Building will add 43 additional beds, taking the total to 410 (22 built as shell only) and 9 additional theatres, taking the total 26 (3 built as shell only). Additional Emergency Department bays (22), imaging suites (9), birthing rooms (2), maternity assessment units (3) and various additional clinical and consult rooms are also planned. These numbers include an additional 9 mental health services for older persons beds which are being built as a shell only for future fitout.

26. An accommodation comparison between the current hospital, the detailed business case, and the current design is attached at Appendix 6.

27. We recommend that investment in improving health service delivery in Dunedin and the wide southern district is justified.

Maintaining current scope, scale and programme of New Dunedin Hospital requires additional funding.

28. Given the amount of planning that has gone into the design of the NDH (including a significant design reset in 2022 to address a $200 million[1] cost escalation), continuing with the project as scoped would present the least risk in relation to programme and the timely delivery of improved health facilities in Dunedin.

29. Further cost escalation in relation to the NDH has become apparent due to trade pricing on the Outpatient Building, continuing inflation and exchange rate risk, design risk, sub-contractor risk, and complexity and location risk now more fully understood.

30. To cover these cost pressures and maintain current programme, utilising the currently planned construction contractor, CPB, a further $170 million is required immediately to enter a construction contract for the Inpatient Building, with a further $120 million to be provided for contingency in B25.

31. Additionally, there are costs that were not included in the business case that require funding. These are:

a. Pathology Laboratory – the current provision of pathology services in Dunedin is split between two laboratories. Both service the hospital and community need. The original design of the NDH contemplated the same split provision with two thirds of the pathology space remaining in the existing hospital. The design reset in 2022 utilised the Australasian Health Facility Guidelines to include a ‘stat’ lab of 350m2 within the NDH and the remainder outside. A pathology review was commissioned by the last Minister of Health which found

[1] A $90 million saving was achieved with an additional $110 million budget provided as part of B22, however, this did result in a 12-month delay (and associated costs) due to much of the design having to be revisited.

that the most efficient method of delivery pathology services in Dunedin is via a new integrated single standalone facility within close proximity of the NDH. This was not provisioned in the business case.

b. Carparking – The provision of on-site parking for NDH is very similar to existing hospital provision and did not change during the design reset. However, the business case stated that an additional 250 carparks to support staff and patients was required, but no funding was provided.

c. Current hospital – the business case mentioned several services that were out of scope for the NDH, but that the new hospital build is reliant on their development occurring by the time the new hospital is commissioned. It was assumed the SDHB would pay for these. There was no mention of the costs associated with the existing buildings and whether they would be demolished or refurbished. No funding has been approved or allocated to cover these costs.

32. Options to fund the required increased in costs, along with the risks and benefits of each, are outlined at Appendix 2. In summary they include:

    a. New Crown Capital.

    b. Reprioritisation of the HCE by deferral of the commitment to full construction costs of other approved or prioritised capital projects. This means only the costs to undertake the design is funded, with the assumption that funding for construction costs will be made available for a construction contract to be entered in future years. No guarantee of funding is made at the time of the deferral.[2]

    c. Third party financing in whole or in part.

    d. Undertake a sale and lease back arrangement for the Outpatient Building.

33. The recommended option to maintain programme is that a commitment is made to providing new Crown capital in immediately thereby allowing construction to continue on the Inpatient Building.

34. Additional funding would be required in outyears as outlined at Appendix 1.

35. The other options were not considered optimal because:

    a. The HCE is fully subscribed, with some projects already deferred in anticipation of B24 funding to cover current cost pressures against the portfolio.

    b. Any deferral of commitments of other projects would shift demand for capital funding into future years, necessitating a significant uplift in funding of investments to address clinical risk and deliver planned clinical services.

[2] This phasing has occurred for the Nelson Redevelopment as once a design is more fully developed, there is more cost certainty to inform the capital costs required for construction.

c. Third party financing would require a funding source to be allocated to the investment to account for the liability incurred, effectively requiring the commitment of capital funds. The result is the same effect as new Crown capital funding and transfers capital costs to more expensive operating costs, with no guarantee that additional operating budget would be made available.

d. A sale and leaseback would take time to negotiate and create delays to the project. It would also transfer capital expenditure to operating expenditure with no guarantee that additional operating budget would be made available.

Options if additional Crown capital is not available.

36. Revisiting scope and scale of the NDH will be required if no new Crown capital is available.

37. A review would revisit the options outlined in the business case and consider:

    a. The impact of changes in the way we are now organised, as one health provider with a regional network of service delivery.

    b. The impact of nationwide changes in the models of care including telehealth, older persons services, and the move to deliver more health services closer to the communities they serve.

    c. If different assumptions are made regarding patient flows across the wider Te Waipounamu Region and the Southern TAs, noting the significant population growth in Central Otago.

    d. If different assumptions are made regarding the right location for supporting tertiary services.

38. It may result in reduced clinical capacity for Dunedin but will require concurrent investment in the wider southern district.

39. Additionally, lessons learned through the progression of the project, based on legacy decisions, have raised several concerns regarding the deliverability of the, currently under construction, Outpatient Building, and significantly increased risks and issues regarding the deliverability of a much larger Inpatient Building.

40. Given the rising costs and complexities of deliverability of such a large project in Dunedin, it may be more feasible to deliver an increased number of smaller projects that are less complex.

41. Any option that revisits the scope and scale will come with risks, particularly clinical risks associated with the delays to delivering improved health facilities and escalation costs. This may not reduce the overall investment required and would erode into the existing appropriation with re-work/sunk costs. The options are outlined in more detail at Appendix 2. In summary they include:

a. Option 5a - Stop all construction and completely reconsider the entire project.

b. Option 5b - Continue with the Outpatient Building as is and revisit the design of the Inpatient Building to make it smaller both in terms of physical size and clinical capacity.

c. Option 5c – build differently such as repurpose the Outpatient Building to an elective surgery centre, make multiple smaller investments in refurbishing current facility including constructing a new clinical services building adjacent to the existing campus, and adding capacity in the wider district.

42. Option 5c is an example of how we could build differently and there may be other nuanced options within this option that will need further investigation.

43. Although detailed planning has not been undertaken on the above options, taking the risks and issues into consideration from a clinical/service planning, deliverability and cost perspective, we recommend that Option 5c – Building differently is further investigated, if no new Crown capital is available.

44. However, the risk of significant stakeholder dissatisfaction should not be underestimated. The current scope and scale of the NDH has been well socialised with local government across the district, community groups and clinicians.

45. Should a redesign option such as Option 5c be considered, the approach would involve:

    a. The Outpatient Building structure and façade continuing without delay whilst a redesign of the interior is undertaken to support, for example, an elective surgery centre.

    b. Service planning and demand modelling to identify how capacity could be reduced in Dunedin through consideration of health service provision across the lower South Island.

    c. The likely refurbishment and reuse of existing buildings, that are not fit for purpose to provide contemporary models of care, reduces the requirement to demolish or refurbish in the future.

    d. The decanting of services and patients whilst building refurbishment took place.

46. The clinical service implications have not been considered in detail as this was not part of the original business case scoping. Therefore, further investigation into the feasibility of Option 5c may take up to 12 months before a report back can be undertaken, detailing what could be achieved and what the estimated costs might be.

47. With Option 5c, once approved, it may be that some projects in the wider southern district would be able to be progressed sooner or in parallel, but a new clinical services building is likely to be delayed past the planned delivery date for the Inpatient Building.

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s9(2)(b)(ii), 9(2)(j) [redacted]

[redacted]

[3] s9(2)(b)(ii), 9(2)(j) [redacted]

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Te Tiriti o Waitangi

56. Aside from the risk of delaying the delivery of improved health services to the southern region, there are no implications for the Crown's obligations under Te Tiriti.

Financial implications

57. The financial implications of continuing with the scale and scope of the currently designed NDH will require additional capital and operating funding both immediately and in the near term.

58. Waiting for a funding decision until the B24 announcement in May 2024 will have the following implications for the project:

    a. Programme will be delayed. We are already in delay due to the election and a further five-month delay means that we will be at least eight months behind.

    b. 9(2)(b)(ii) The current delay costs are included in the $170 million.

    c. s9(2)(b)(ii), 9(2)(j)

59. Revisiting the scope and scale required in Dunedin and investigating the provision of improved health services in the wider southern district could result in better placed health facilities and could reduce the overall capital funding required. However, it will likely increase operating funding, this is subject to further investigation being undertaken over the next 12 months. Refer Appendix 1.

Next Steps

60. Depending on the decision made by the Joint Ministers, Te Whatu Ora will either continue with the project as planned or begin investigating Option 5c and report back within 12 months.

61. If Option 5c is the decision, a communication plan will be developed in conjunction with the Minister of Health's office.

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Minister's Comments

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Appendices

Appendix 1 – Decisions made on NDH and resultant issues.

Date	Decision	Budget
July 2017	Indicative Business Case approved by Cabinet. Cabinet approved a greenfield redevelopment of core Dunedin Hospital buildings on either a new site or the Southern DHB owned Wakari site at an estimated cost of $1.2 billion to $1.4 billion.	$1.2 billion - $1.4 billion
November 2018	Cadbury Factory site purchased	
April 2021 [CAB-21-MIN-0124]	Detailed Business Case approved by Cabinet agreeing to new site in Dunedin CBD.	$1.47 billion
February 2021	New Governance of the New Dunedin Hospital put in place resulting from a Gateway Review recommendation.	
March 2022 [HR20220041]	Due to cost pressures estimate at $200 million from scope creep and inflationary pressures from COVID-19, Joint Ministers agreed to a series of cost saving measures that equated to $89 million, with an additional funding requirement of $111m being recognised as a pressure against the Budget 22 appropriation. Joint Ministers noted that any further significant deviations from what has been agreed needed approval from Joint Ministers	$1.47 billion
May 2022	s9(2)(a), 9(2)(g)(i)	
December 2022 [HNZ00008490]	Joint Ministers agreed to value management savings of $90 million and released the Budget 22 provision of $110 million.	$1.58 billion
January 2023	Enhanced Project Governance implemented in line with Te Waihanga advice.	

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Date	Decision	Budget
April 2023 [HNZ00015667]	Joint Ministers agreed to $10 million additional funding to cover the cost of: • A completion of the review of the pathology services • A review into mental health services for older people capacity to ensure that the capacity provided is appropriate into the future • The purchase of an MRI machine • Fit out of shelled collaborative spaces	$1.59 billion
June 2023 [HNZ00019210]	The Ministers of Health, Finance and Education agreed to a recommendation that, due to budget constraints and cost pressures being experienced by Te Whatu Ora, Te Pūkenga and the University of Otago, meant that while Interprofessional Learning remains a priority, building a new Interprofessional Learning Centre is no longer financially feasible nor a priority.	Estimated costs for ILC were estimated to exceed $140 million, making each parties' share >$50 million. The amount budgeted for the ILC in the NDH project budget was $17 million.
May 2023 [HNZ00029011]	The outcome of the pathology review was recommended that a new 4000m2 building incorporating an integrated hospital and community pathology lab was the most efficient method of delivering pathology services. Initial cost estimates of this option were around $45 million. However, no location for this building has been identified and no funding is available. If adopted, it may be that the pathology service provider or other private sector developer could undertake the build, but this would need further investigation	Early estimates of cost for the provision of a stand-alone pathology building is $45 million (excluding fitout). This is not currently funded so the pathology provision will stay in the old hospital until funding is available.

Issues arising from these decisions:

1. The scope, budget, and programme issues that have plagued NDH since its inception is due to poor planning, poor governance and political decisions and any real understanding of the risks associated with this project.

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2. The issues resulting from those poor decisions include, but are not limited to:

    a. **Site selection** - extraordinary cost premiums associated with land purchase and demolition costs, contaminated ground, archaeological surveys /excavations, piling difficulty, flood level risk, water table depth and access issues due to it being built on a traffic island in the middle of State Highway 1. The alternative location at Wakari Campus, using the spare land available would have saved significant money.

    b. **Building footprint** – the decision to build initially three, now reset to two buildings, rather than one as originally envisaged, has significantly increased the complexity and cost of development.

    c. **Fast Track programme** - s9(2)(b)(ii) [redacted]

    d. s9(2)(b)(ii), 9(2)(j) [redacted]

These legacy decisions have led to significant risk being transferred to Te Whatu Ora. To s9(2)(a), 9(2)(g)(i) [redacted], implemented improved Governance, reset the design down to two buildings (instead of three), supported the cancellation of the Interprofessional Learning Centre, and taken $90 million of costs out through a design reset.

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Appendix 2 – Breakdown and timing of funding required.

Funding requirement	**Current funding**	**When funding is required**	**Options**
NDH appropriation	$1,590 million capex		
Data and Digital tagged contingency	$225 million capex		
Total current funding approved	***$1,815 million capex***		
Additional funding required to complete the original business case			
s9(2)(b)(ii), 9(2)(j)			
Total additional funding required to complete the original business case	***$290 million capex***		

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Funding requirement	Current funding	When funding is required	Options
Additional funding required for items not in the original business case			
Pathology Lab - capital	~$45 million capex	2025	Alternative funding arrangements will be investigated for the pathology lab. If unsuccessful then new Crown capital would be required. The options could be seeking the service provider providing the building or, third party developer financing or partnering with Iwi.
Carparking	s9(2)(b)(ii), 9(2)(f)(iv)	2027	Alternative funding arrangements will be investigated. If unsuccessful then new Crown capital would be required. Third party funding for car parking has been successfully used on other sites across the country where the commercial model makes sense.
Reuse/decommissioning existing hospital	~$325 million capex	2029	Building differently as per Option 5c would reduce this cost as it would reusing the existing facilities. There could also be potential to work with third parties, such as the City or University of Otago, to identify alternative uses or ownership to reduce this burden.
Total additional funding required for items not in the original business case	s9(2)(b)(ii), 9(2)(f)(iv)		Alternative funding arrangements will be investigated for the car park. If unsuccessful, then new Crown capital would be required. Third party funding for car parking has been successfully used on other sites across the country.

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Funding requirement	Current funding	When funding is required	Options
Total additional capital required	s9(2)(b)(ii), 9(2)(f)(iv)		
TOTAL CAPITAL FUNDING	s9(2)(b)(ii), 9(2)(f)(iv)		
Additional workforce operating costs	~$108 million opex	FY 25/26 and FY 28/29	

Notes:

- The cost estimate does not include the fitout of the additional Mental Health Services for Older People beds as they are not deemed to be required upon opening.
- s9(2)(b)(ii), 9(2)(j)
- Cost management has been a significant issue on this project with pressure on budget increasing due to several factors outside the control of Te Whatu Ora. Attached is a list of additional costs estimated above the appropriated budget.
    - The Outpatient Building contains services which require plant and equipment that is normally associated with a building of a much larger scale. Accordingly, the cost is much higher than would be otherwise expected for a building of this scale. Furthermore, pushing the Outpatient building into construction at a time when construction inflation was high has resulted in an inflated trade costs compounded by only having one contractor (Southbase) bid the job. The construction cost has increased by $76 million from initial pre-tender estimates, which has been drawn from wider programme contingency.
    - s9(2)(b)(ii), 9(2)(j)

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- The Inpatient Building design was reset to improve cost and function, resulting in $90 million saving. Post the reset, the project is now in the Developed Design phase and is in the process of having the 50% Developed Design cost estimated by our QS. The estimate has highlighted several issues that are contributing to the cost issues and would not have ordinarily been known until this stage. These include addition foundation and piling work on Bow Lane, the cost of the increase in Probabilistic Seismic Hazard Analysis 2 rules changing, piling issues on the existing site, additional dewatering requirements resulting from the recently issued resource consent, additional cranage now needed due to the shape of the reset design, logistic costs particularly in transport costs, exchange rate fluctuations and prolongation.
- New Zealand inflation rates continue to exceed expectations and such impacts are being realised in trade pricing being received with labour, material and risk being incorporated. A change of methodology to a managing contractor model on the Inpatient Building will assist in controlling the apportionment of risk.

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Appendix 3 – Funding options to continue with scale and scope.

#	Option	Benefits	Risks
1	• New Crown funding to cover immediate cost pressures	• No delay to NDH if commitment made. • Keeps HCE "whole" • No redesign required	• Delay to programme if additional funding if required to wait until B24 decision. • Further capital and operational funding required in out years to cover costs associated with the construction of the NDH i.e., carparking, pathology laboratory, operational costs, and refurbishment/demolition of existing buildings. • Further funding may be required if decision is made to go back to market for a main contractor as price is likely to change.
2	• Re prioritise Health Capital Envelope	• No delay to NDH • No redesign required	• Requires deferring the construction of other approved or planned capital projects increasing health service provision risk and clinical risk. • No guarantee of additional funding in out years to cover deferred projects. • Some approved projects have already been deferred to cover other costs pressure across the portfolio. • Significant stakeholder dissatisfaction with cancelling or postponing other announced projects. • Further capital and operational funding required in out years to cover costs associated with the construction of the NDH ie. carparking, pathology laboratory, operational costs and refurbishment/demolition of existing buildings. • Further funding may be required if decision is made to go back to market for a main contractor as price is likely to change.

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#	Option	Benefits	Risks
3	• Third party financing in whole or in part	• Keeps HCE "whole" • Potential to be used for pathology and carparking also.	• Requires the Crown to identify a funding source would need to be allocated to such investment to account for the liability incurred, effectively requiring the commitment of capital funds anyway. • Delay to programme for negotiating alternate funding deal. • Transfers capital expenditure to operating expenditure with no guarantee of additional baseline operating funding being available. • Operating costs more than capital charge, which is funded. • Further capital and operational funding required in out years to cover costs associated with the construction of the NDH ie. operational costs and refurbishment/demolition of existing buildings • Further funding may be required if decision is made to go back to market for a main contractor as price is likely to change.
4	• Sell OB to 3rd party and lease back under an operating lease.	• Frees up cash for Inpatient Building • No delay in delivery as Outpatient Building is continued. • No redesign required.	• Risks associated with not owning the facility via restrictions to use and flexibility of changes. • Transfers capital expenditure to operating expenditure with no guarantee of additional baseline operating funding being available. • Operating costs more than capital charge, which is funded. • Further capital and operational funding required in out years to cover costs associated with the construction of the NDH ie. operational costs and refurbishment/demolition of existing buildings • Further funding may be required if decision is made to go back to market for a main contractor as price is likely to change.

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Appendix 4 – Options that revisit scale and scope to remain within appropriation.

#	Option	Benefits	Risks
5a	• Complete redesign of a new hospital	• New facilities provided in Dunedin.	• At least a three-year delay until construction could commence and delivery of new health facility. • Reduced scope and scale not future proofed and may run out of capacity earlier than expected, so may require additional investment in Dunedin sooner than currently planned. • May require additional investment outside of Dunedin to meet demand. • Additional funding still required for demolition/refurbishment of existing buildings. • If one large building is planned the issues relating to delivery of large-scale infrastructure in Dunedin remains. • Sunk costs. • Significant stakeholder dissatisfaction.
5b	• Keep going on Outpatient Building and revisit current Inpatient Building design to reduce size and scale	• No delay in Outpatient Building delivery. • Reduced funding requirement for Inpatient Building	• Delay to delivery of Inpatient Building with at least a two-year delay until construction could commence. • Reduced scope and scale not future proofed and may run out of capacity earlier than expected, so may require additional investment in Dunedin sooner than currently planned. • May require additional investment outside of Dunedin to meet demand. • Additional funding still required for demolition/refurbishment of existing buildings. • Sunk costs. • Significant stakeholder dissatisfaction.

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#	Option	Benefits	Risks
5c	• Repurpose Outpatient Building to elective surgery centre. • Build new Clinical Services Building adjacent to existing hospital. • Upgrade existing hospital where required. • Invest in wider district ie. Central Otago, Invercargill, and Queenstown	• Separation of acute and elective streams to enable greater efficiency. • Provides additional theatre capacity at Dunedin. • Easier to deliver many smaller projects than one large project. • Additional theatre capacity, ED expansion and ward beds in Invercargill. • Expansion of inpatient beds and ED and services at Queenstown and Dunstan. • Undertaking proper planning for a new hospital in Central Otago	• May be a six – 12-month delay to Outpatient Building. • 12 – 24-month delay for Clinical Services Building over current planned Inpatient Building delivery date. • Decanting of patients and services whilst buildings are upgraded to be able to provide a more contemporary model of care. • Sunk costs. • Significant stakeholder dissatisfaction.

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s9(2)(b)(ii), 9(2)(j)

[redacted]

[4] s9(2)(b)(ii), 9(2)(j) [redacted]

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6. s9(2)(b)(ii), 9(2)(j)

s9(2)(b)(ii), 9(2)(j)

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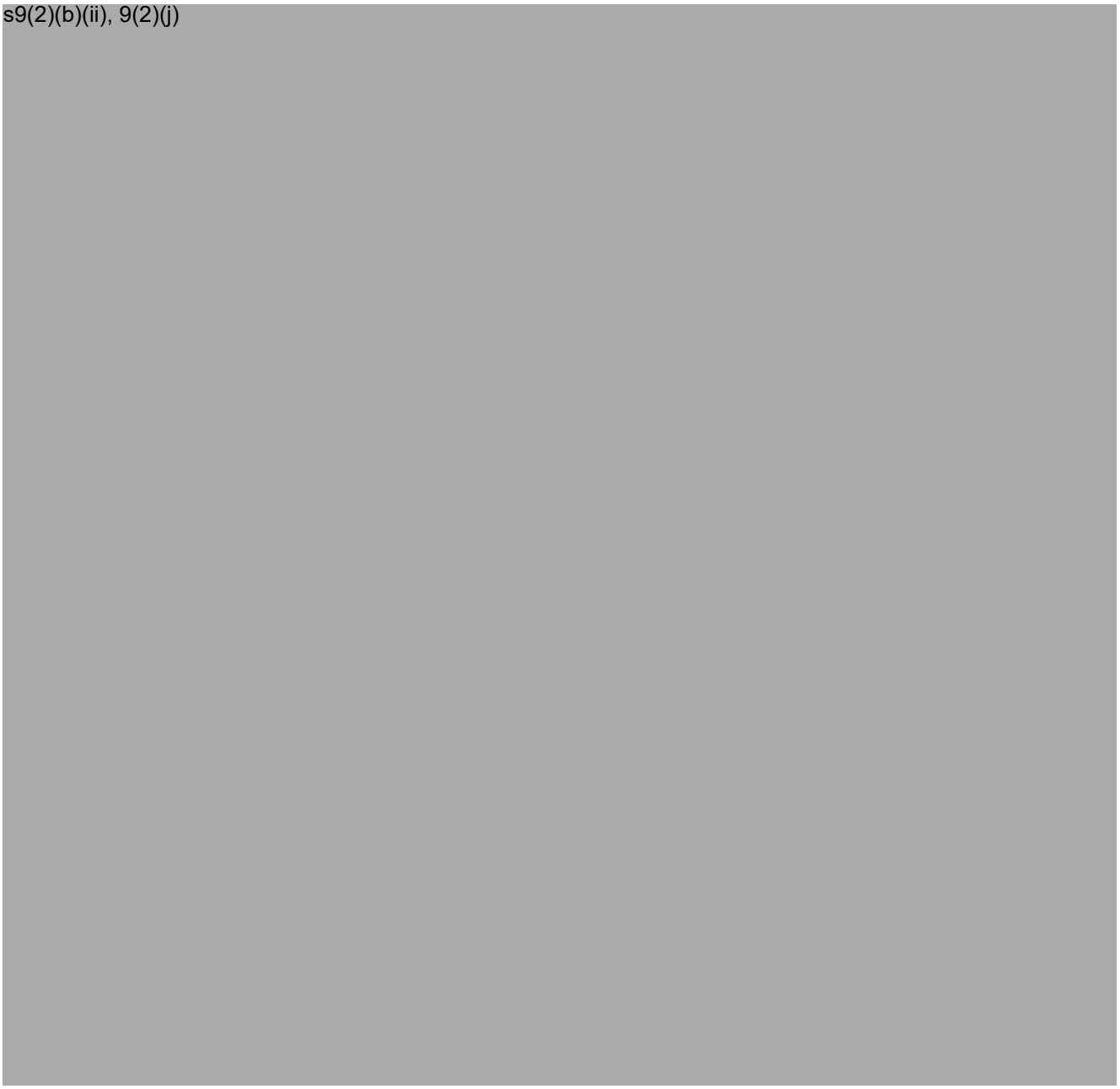
s9(2)(b)(ii), 9(2)(j)



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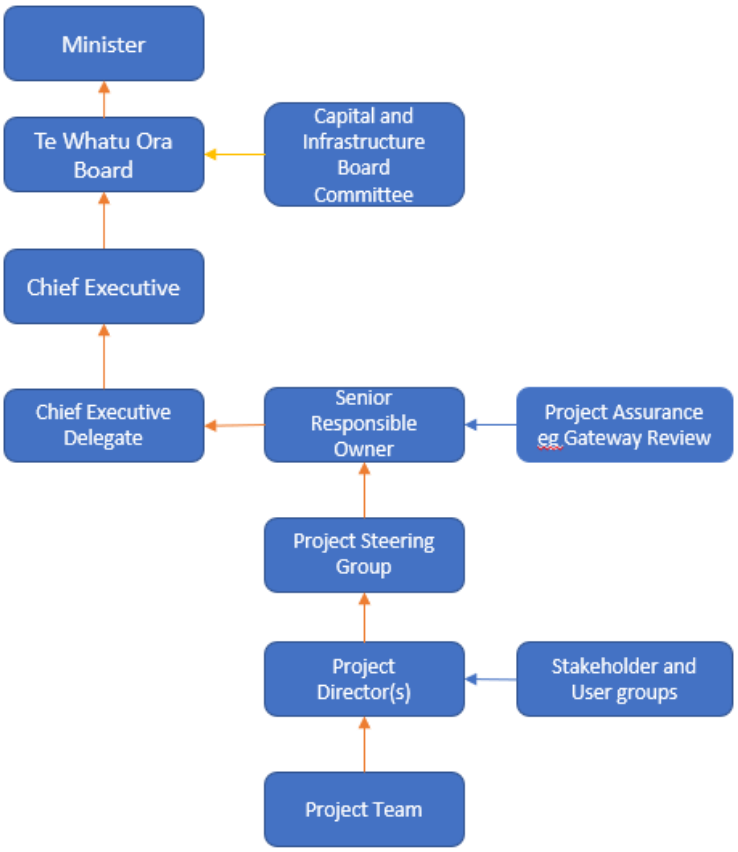
Appendix 6 – Governance and Management arrangements

The governance model for NDH is summarised in the diagram and key elements are discussed below:



Accountabilities are clear in that they flow from the project team through project governance to the Senior Responsible Owner (SRO) to the Chief Executive (CEO) to the Board. The Capital and Infrastructure Committee is advisory to the Board.

Capital and Infrastructure Committee (Committee)

The members of the Committee are made up of Board members and independent expert advisors. The Board members are Naomi Ferguson as Chair and Hon. Amy Adams. The advisors are:

- Scott Pritchard – CEO - Precinct Properties
- Mei Fern Johnson – Partner – Russel McVeagh
- Lale Iremia – Director – PCM Consulting

The Terms of Reference for the Committee include oversight of major projects. The NDH project has been visited by the Committee Chair and the Committee has been involved in a number of reviews of the project.

Senior Responsible Officer (SRO)

The SRO for NDH is currently Dr Tony Lanigan who has significant construction experience (he has held senior roles within Fletcher Construction, Director of Infrastructure Auckland for five years, and was the first Chancellor of the Auckland University of Technology). As shown above there will is a single point of accountability through the SRO, who will be responsible and accountable for the project's success. This point of accountability makes 'best for project' decisions outside of day-to-day operations.

The SRO must be appropriately experienced and reports directly to the CEO or their delegate, in this case the Chief Infrastructure and Investment Officer. The SRO has authority to make decisions within agreed tolerances and is the link between the organisation's senior executive body and the project.

The SRO role is supported by the project steering group and a project management team led by a project director, in this case Mr Tony Lloyd, who delivered the Waipapa Building in Christchurch, Burwood Hospital and Greybase Hospital.

Major health projects are likely to require a mix of infrastructure build, system transformation and IT transformation. The SRO for these projects will be supported by the right skills and expertise on project steering group in all those workstreams. There will be three workstream leads reporting to the project steering group.

Project Steering Group

For major infrastructure projects, the project steering group will be equipped with the mix of expertise required to successfully achieve project outcomes across all workstreams.

For major infrastructure projects, membership of the project steering group will include the SRO as Chair; representation from mana whenua or Iwi; and expertise in governance, major project delivery, health sector, ICT, government, whole of life asset management and business change management.

Project steering group members' expertise will likely be required to change over the life of the project and be aligned to the focus of the project.

Independent members are likely to be required to provide expertise not available within Te Whatu Ora and may be shared amongst many major projects to enable consistency of advice.

The current steering group members that supports the SRO consists of:

- Dr Vanessa Thornton – CMO – Counties Manukau
- Hamish Brown – Group Director Operations – Southern
- Dr Murray Milner – Independent IT Specialist

- James Allison – Regional Director Data and Digital
- Monique Fouwler – Interim Head of Infrastructure Delivery (soon to be replaced by Blake Lepper, ex Te Waihanga)
- Donna Matahaere-Atariki – Iwi representative
- Emma Wyeth – Iwi representative
- Joseph Tyro – Te Aka Whai Ora representative

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Health New Zealand

Briefing

Draft Cabinet Paper: New Dunedin Hospital Cost Pressure Funding and options

Date due:	8 February 2024	**Priority:**	Urgent
Security classification:	Budget - Sensitive	**Reference:**	HNZ00037416
Copy to:			

Minister:	**Action sought:**	**Action required by:**
Hon Dr Shane Reti, Minister of Health	**Agree** to one of the two options to fund the $170 million in cost pressures for the New Dunedin Hospital through the transfer of funds from the Health Capital Envelope by either: s9(2)(g)(i)	12 February 2024
Hon Dr Shane Reti, Minister of Health	**Agree** to provide an update to Cabinet in July 2024 on a medium to long term approach to fund the health capital pipeline as a way of providing assurance to Ministers on the intention to improve planning and costing of Capital works in the future.	12 February 2024

Contact for discussion			
Name	**Position**	**Phone**	**1st contact**
Jeremy Holman	Chief Infrastructure & Investment Officer	s9(2)(a)	X
Monique Fouwler	Interim Head of Infrastructure Delivery	s9(2)(a)	

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The following departments/agencies have been consulted:
The Treasury, Ministry of Health

Minister's office to complete

☐ Approved ☐ Declined

☐ Noted ☐ Needs change

☐ Seen ☐ Overtaken by Events

☐ See Minister's Comments ☐ Withdrawn

Comments:

Te Whatu Ora
Health New Zealand

Briefing

Draft Cabinet Paper: NDH Cost Pressure Funding and options to fund NDH cost pressures

Date Due:	8 January 2024	**Action required by:**	12 February 2024
Security classification:	Budget - Sensitive	**Priority:**	Urgent
To:	Hon Dr Shane Reti, Minister of Health		
Copy to			

Purpose

1. This briefing provides you with a draft Cabinet Paper, seeking Cabinet agreement to fund immediate cost pressures faced by the New Dunedin Hospital (NDH) project, as requested.
2. This briefing also seeks your agreement to one of two options for short-term funding of this cost pressure by transferring funding from the Health Capital Envelope Appropriation by rephasing funding from other projects.

Recommendations

Health New Zealand recommends that you:

a) **Note** the draft Cabinet Paper on New Dunedin Hospital cost pressures attached, as requested at the Joint Ministers' meeting on 31 January 2024. Noted

b) **Note** that due to cost escalation, planning and design issues, the New Dunedin Hospital project requires additional funding of $170 million s9(2)(b)(ii), 9(2)(j) Noted

c) **Note** that these cost pressures can be met immediately by transferring money from the Health Capital Envelope, appropriated for other projects, to the New Dunedin Hospital appropriation. Noted

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d) **Agree** to one of the following options to allocate from within the Health Capital Envelope to make the $170 million available:

1. s9(2)(g)(i) — Yes / No
2. — Yes / No

e) **Note** that we have prepared a cost pressure budget submission to seek funding to recover the $170 million as cost pressure funding for the Health Capital Envelope Appropriation through the Budget 2024 process. — Noted

f) **Note** the expected additional contingency funding of approximately $120 million to cover ongoing risk for New Dunedin Hospital at Budget 2025, which will be supported by a Quantitative Risk Assessment and further information consistent with the scope and intent of an implementation business case in December 2024. — Noted

g) **Note** that we expect to make further budget submissions in outyears (to 2029) which could total up to s9(2)(b)(ii), 9(2)(f)(iv) in Capital, to cover the provision of pathology lab, carpark, and costs associated with the decommissioning or reuse of the existing hospital facilities. — Noted

h) **Note** the Infrastructure Investment Plan and National Asset Management Strategy that was presented to you in December 2023. — Noted

i) **Agree** to provide an update to Cabinet in July 2024 on a medium to long term approach to fund the health capital pipeline as a way of providing assurance to Ministers on the intention to improve planning and costing of Capital works in the future. — Yes / No

Hon Dr Shane Reti
Minister of Health

Date:

Jeremy Holman
Chief Infrastructure & Investment Officer
Infrastructure & Investment Group
Te Whatu Ora – Health New Zealand

Date:

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Summary

3. Cost escalations of $170 million have been identified in relation to the NDH. s9(2)(b)(ii) 9(2)(j) [redacted]
4. s9(2)(b)(ii), 9(2)(j) [redacted]
5. s9(2)(g)(i) [redacted]
6. [redacted]
7. [redacted]

Background

8. Our previous advice to you, ahead of the Joint Minister's meeting on 31 January, [HNZ00035758 refers] confirmed:
    a. The strategic imperative to continue with the NDH project and the benefits that NDH would provide to the people of Dunedin and the wider Southern district.
    b. That costs had increased and provided options in relation to stopping or pausing the project.
    c. There is still risk in the cost estimates and that further costs associated with the NDH project will need funding.
    d. That CPB Contractors have been through a tendered procurement and is our preferred contractor.
    e. s9(2)(b)(ii), 9(2)(f)(iv), 9(2)(j) [redacted]
    f. The expected delivery dates for the NDH and the improved and robust governance and management structure that will support its delivery.

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9. s9(2)(g)(i) [redacted]

10. On 31 January 2024 you met with Ministers of Finance and Infrastructure to discuss the NDH project and you asked for a Cabinet paper to address the immediate cost pressures associated with the project by utilizing funding within the HCE.

We seek a decision on which funding to rephase

Process used to identifying projects for rephasing funds.

11. Since November, the Infrastructure Investment Group (IIG) and Hospital & Specialist Service (HSS) have been working together to prioritise the options for the rephasing of funds from current projects. The process used to assess viability of options to prioritise funds away from current projects was as follows:

    a. Exclusion of those projects in main contractual commitments.

    b. Projects critical to site-wide supporting infrastructure exempted.

    c. Assessment of changes to projects or rephasing of funds that did not have an immediate impact on delivery progress.

    d. Prioritising other changes on basis of lowest risk to clinical service delivery.

12. The Board reviewed the viable options from which funding could be rephased in the short term and note that each involved projects with identified clinical need and existing community expectations, such that any failure to replenish those funds in subsequent budget rounds will have significant impact on health services.

13. s9(2)(g)(i) [redacted]

14. We seek your agreement on your preferred option. These options are described in detail below. The draft Cabinet paper outlines the preferred option however, we will update the paper to reflect your decision.

s9(2)(b)(ii), 9(2)(f)(iv) [redacted]

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s9(2)(b)(ii), 9(2)(f)(iv)

[redacted]

Option 2: Rephase funding from a mix of two projects

21. s9(2)(b)(ii), 9(2)(f)(iv)

[redacted]

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s9(2)(b)(ii), 9(2)(f)(iv)

23. s9(2)(b)(ii), 9(2)(f)(iv)

Recovering the $170 million through Budget 2024

26. Rephasing funding from the Health Capital Envelope will have clinical and infrastructure integrity risks across the health capital portfolio.

27. We recommend that you make a submission to the Budget 24 process seeking cost pressure funding for the Health Capital Envelope Appropriation. We have prepared a submission that will be included in your briefing from the Ministry regarding Budget 2024 this weekend.

Reporting back to Joint Ministers on a Qualitative Risk Assessment by December 2024

28. Throughout 2024 we will continue work on the design and foundations of the Inpatient Building at NDH. Long lead items, such as steel, will be ordered and we will continue to work with CPB on developing and refining the total out-turn costs. At the conclusion of this work, we will report back to you, ahead of Budget 25, and provide you with further information consistent with the scope and intent of an implementation business case, including a Quantitative Risk Assessment (QRA). We will also provide an update on how much additional funding may be required for NDH from Budget 25.

Briefing: HNZ00037416: Draft Cabinet Paper: NDH Cost Pressure Funding and options to fund NDH cost pressures

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29. s9(2)(b)(ii), 9(2)(f)(iv) [redacted]

32. Projects as large and as complex as NDH, Nelson and Whangārei need a more robust approach to planning than has been seen in the past. For Nelson, we provided a programme business case that outlined what the full cost could be and sought agreement that the strategic case is robust, and investment is required. Funding was also sought to enable further design to eliminate much of the risk and provide early contractor engagement to ensure that buildability is considered. This allows a more confident cost estimate to be provided in a detailed business case. This approach is recommended for all major health infrastructure projects.

33. As discussed in the attached Cabinet paper, the historical approach to health capital prior to the establishment of Health New Zealand lacked coordination, and bespoke arrangements were not accountable to national health and capital outcomes. The Cabinet paper also outlines steps we have taken to improve this approach, including the development of the Infrastructure Investment Plan (IIP). The IIP provides the first national view of the priorities and timeline for infrastructure investment to sustain and enhance clinical health service delivery. This will support more robust planning and investigation of options ahead of the final business case decision on investment. This includes the investment in design and delivery planning to reduce uncertainty, to provide Ministers greater confidence on the expected costs for the investments. We recommend providing an update to Cabinet in July 2024 on a medium to long term approach to fund the health capital pipeline, in line with the IIP, as a way of providing assurance to Ministers on the intention to improve planning and costing of Capital works in the future.

Te Tiriti o Waitangi

34. The business cases that support each of the projects proposed for rephasing, and the development of the Infrastructure Investment Plan have the health sector principles, Te Tiriti o Waitangi, and equity of access and outcomes as essential considerations, in line with the Pae Ora (Healthy Futures) Act 2022.

Financial implications

35. The financial implications of continuing with the scale and scope of the currently designed NDH to the agreed timeline requires immediate rephasing $170 million of

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funding in the HCE appropriation, already appropriated to other projects. To avoid risk of delay for other projects, we will provide with a Budget 24 submission to top-up the Health Capital Envelope.

36. s9(2)(b)(ii), 9(2)(f)(iv) [redacted]

Next Steps

37. Subject to your decision on this paper, we will provide an updated Cabinet Paper to your office by 15 February for lodging the paper with the Cabinet office.

38. The table below provides a timeline of next steps

Draft Cabinet paper to the Minister's office	8 February
Ministerial Consultation begins	9 February –14 February
Minister of Health Decision on preferred option due, changes to reflect Ministerial feedback	12 February
Lodge draft Cabinet paper with Cabinet office	15 February
Consideration by Cabinet Committee	19 February
Consideration by Cabinet	26 February

39. HNZ will provide you, the Minister of Infrastructure and the Minister of Finance with Qualitative Risk Assessment informed by fully developed design, up-to-date pricing information and risk assessment akin to an implementation business by December 2024. This will provide assurance that the project remains on track and inform further funding decisions.

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Minister's Comments

Aide-Mémoire

Improvements in infrastructure planning and delivery

To:	Hon Dr Shane Reti, Minister of Health	**Reference:**	HNZ00037099
From:	Jeremy Holman, Chief Infrastructure and Investment Officer, Infrastructure and Investment Group Health New Zealand	**Due Date:**	15 February 2023
Copy to:		**Security level:**	In Confidence

Contact for telephone discussion (if required)			
Name	**Position**	**Telephone**	**1st contact**
Monique Fouwler	Interim Head of Infrastructure Delivery, Infrastructure, and Investment Group, Health NZ	s 9(2)(a)	x
Jeremy Holman	Chief Infrastructure and Investment Officer, Infrastructure, and Investment Group, Health NZ	s 9(2)(a)	

The following departments/agencies have been consulted
NA

Attachments	Appendix 1: New Dunedin Hospital Lessons Learned

Improvements in infrastructure planning and delivery

Purpose

1. This Aide-Mémoire responds to your request for:
    a. Advice on lessons learned from the New Dunedin Hospital (NDH) project, and any other projects, and how Health New Zealand | Te Whatu Ora (Health NZ) has responded through an improved, nationally led planning and delivery approach; and
    b. Information regarding changes to key staff and the governance of infrastructure, including how things have now improved compared to how infrastructure was planned and delivered under the District Health Board (DHB) model.

Background

2. The previously fragmented structure of the health system meant that some DHBs didn't have the capability to implement good asset management and planning practices and deliver large scale infrastructure projects. In the past, if Health was invited to submit a capital budget bid, the Ministry of Health (the Ministry) sought information from individual DHBs on their capital intentions.
3. The system of obtaining funding had a number of issues where the DHBs responded to the capital intention requests in the best ways they could. However there was a lack of certainty as to the outcomes of the capital intentions requests, and as such this could result in inaccurate cost estimates from the outset.
4. Once the capital intentions were received by the Ministry, they would be assessed and prioritised, and this list of projects would be submitted as a budget bid based on the indicative costs submitted by the DHBs. The fragmented nature of the old health system meant that the projects submitted by the individual DHBs lacked coordination in terms of a national approach. If the budget bid was successful, the DHB was then invited to submit a business case to the Ministry before they could draw down on the appropriation.
5. DHBs then developed detailed business cases, the quality of which could be variable depending on the size and capability of the DHB and the funding available for the business case development and project planning. This could result in cost estimates being provided that did not always reflect the actual cost of the projects or contain enough allowances for escalation and contingency.
6. Once the business cases were approved, funds for the projects could be drawn down and more detailed project planning could commence. As the detailed planning progressed it sometimes became apparent that the original budget was insufficient to cover the true costs of the projects. Engaging with the construction industry and delivering health infrastructure is a complex business, and some of the DHBs lacked appropriate resourcing and capabilities to deliver large projects.
7. The Mental Health Infrastructure Programme Deep Dive, undertaken by the Te Waihanga, noted the following regarding the process outlined above:

Common, underlying issues have been observed on these projects include:

The lack of a long-term national investment strategy – which made it difficult for projects to understand in advance the likelihood of funding certainty. This created a system unwilling to invest significantly in investment planning and a pattern of 'light touch' business cases. Which in turn led to projects being announced with schedules and budgets that later had to be modified (when detailed business case/design work showed up the true realities of the situation).

Approval pathways, delegations and sign-off processes were not well understood by the district teams. Further, timing to provide approvals took longer than project schedules had allowed for.

Apparent lack of forward planning to drive an overall investment strategy in some cases led to location or scope of individual investments changing after the business case was approved – which then caused considerable delays.

Discussion

Benefits of a single entity to support improved infrastructure delivery.

8. The establishment of Health NZ provided the opportunity to improve the way projects are planned and delivered through:
    - National and regional service planning;
    - Bringing together and strengthening national and regional infrastructure capability
    - The ability to plan and prioritise nationally, co-ordinate regionally and deliver locally, as evidenced by the development of a National Asset Management Strategy and Infrastructure Investment Plan and the implementation of the Infrastructure and Investment Group's new operating model;
    - Improved project governance;
    - Standardisation of design by way of Facility Design Guidance document and standardised fire, structural and engineering design guidance;
    - Improved project planning, business case development and phased funding;
    - The ability to share and learn lessons across the motu, including benchmarking across projects.
9. To improve project planning and delivery, Health NZ has established a methodology in line with how the private sector plans and delivers projects, but with public sector sensitivities incorporated.
10. This methodology involves undertaking nationally-led service and asset management planning to understand where, based on evidence, investment is required due to increasing demand or poor asset performance. Non-capital solutions, such as commissioning, are considered.
11. Once this prioritisation has been established and agreed, funding is sought to undertake an options analysis, including non-capital solutions, to address the investment need.

This would include verification of the strategic case, the development of a functional brief and a schedule of accommodation based on the service planning and standardised models of care.

12. This will then allow for an indicative business case to be provided with a range of options, a high-level range of costs and a preferred option.
13. If there is still support for the investment, funding will be sought to investigate the preferred option more thoroughly through to developed design. For larger projects this may include early contractor engagement, whereby a better and more robust cost and programme estimate can be established and many of the risks and issues resolved.
14. A detailed business case would then be developed to seek continued support for the investment and funding sought for the construction of the project.
15. This phased approach to project planning provides transparency on whether the project remains value for money and will deliver on the benefits established. It also allows for a cash flow approach to be established.
16. In addition, for large hospital redevelopment projects, more emphasis will be placed on reusing existing infrastructure and staging investment over time to support smaller, more deliverable projects, over several years, rather than a build as big as NDH which is too large for the New Zealand market. By developing a staging plan, this will also ensure that the full extent of the investment is understood in advance, albeit at a high level.
17. It will be important that discussions occur regarding the current capital settings and the way budget bids are invited to support this methodology so as not to repeat the errors of the past.

Specific improvements for New Dunedin Hospital since the establishment of Health NZ

18. Following Treasury Gateway Review recommendations and the guidance of Te Waihanga on the governance of major projects, changes have been made to the governance and management of NDH. The changes included:
    - The terms of reference for the project now include the oversight of the data and digital and workforce transformation workstreams. Previously these were separate and not joined up;
    - Regional representation has been included on the steering group to ensure that what is being delivered aligns with the scope agreed and regional and national planning;
    - National delivery representation has been included on the steering groups for major projects to ensure there is consistency and efficiencies being made across projects;
    - Independent experts have been retained on the steering group to add capability;
    - Programme and project management has been strengthened with experienced programme and project directors;
    - The establishment of the Capital and Infrastructure Board Committee, the terms of reference of which include the oversight of major projects. The Committee and

Board receive monthly reports on NDH, and the Committee have had a number of deep dives into NDH and provided support and guidance.

19. The lessons learned to date for NDH are attached in Appendix 1. These outline the lessons and changes that have been, and are being, implemented by Health NZ.

Appendix 1 – New Dunedin Hospital Lessons Learned

New Dunedin Hospital Project- Lessons Learned Summary

This summary focuses on key lessons that have been identified within the construction, service transformation and digital infrastructure workstreams. These key lessons will be applied within the current/future Health NZ Infrastructure and Investment project environment.

Background

The New Dunedin Hospital (NDH) project began in 2015 with the Indicative Business Case being approved by Cabinet in July 2017. Cabinet approved a greenfield redevelopment of core Dunedin Hospital buildings on either a new site or the Southern DHB owned Wakari site at an estimated cost of $1.2 billion to $1.4 billion. Site selection commenced soon after. In April 2018 Cabinet agreed the Cadbury and Wilson Blocks in Dunedin as the preferred new hospital site. These blocks were acquired in May 2018 and December 2019 respectively.

Lessons – initial phases

The key lessons captured in this report cover the period since 2018 when project establishment and site master planning activities enabled the earlier design development phases of the hospital to get underway. The initial activities primarily involved replacing the existing project team with new project leadership, setting up the clinical user groups to inform the Preliminary Site Masterplan Report and Concept Design, completing the land purchases and re-commencing the procurement of the design disciplines to support the design development phase of the new hospital.

The capture of more detailed lessons from the recently completed Outpatient Building design process is scheduled for early 2023. These lessons will be considered by the Inpatient Building project team throughout the remaining design phases for that building.

Common themes

The common themes identified from the lessons learned to date are:

- **Governance** – the need for well-structured and integrated governance between project-level governance and organisation-level governance where roles, responsibilities, accountabilities and decision-making authority are defined and understood. Having the confidence of all relevant stakeholders is critical to the successful delivery of the project.

- **Investment and business cases (scope)** – project scope inclusions and exclusions must be detailed at the outset to achieve a clear definition, understanding and agreement of project scope by all stakeholders. This will enable them to be appropriately managed and priced.
- **Investment and business cases (scope)** – the business case should be inclusive of the construction, service transformation and digital infrastructure workstreams so that approvers understand the full commitment required in order to build and open a new hospital.
- **Services planning (capacity)** – demand and capacity planning and models of care are critical precursors to the design of the building. These activities need to be aligned to Health NZ nationally-led strategic policy positions / overarching functional principles for key capacity elements, such as overnight beds and theatres, to direct design decisions.
- **Services planning/master planning (scope creep)** – the process and scope of clinical user engagement must be well-defined and aligned with Health NZ national policy statements on models of care. The primary focus must be on function and how clinicians / other personnel wish to work / deliver services in the future.
- **Planning/Stakeholder Engagement** – establishment of Workforce Central Dunedin (WFCD) has led to a collaborative community, government and industry approach to grow the local construction workforce. This is a template for other industries to follow to attract new trainees.
- **Design development (value management/value engineering)** – the approach to the value management / value engineering process must be documented and undertaken promptly at each stage of the design. This will help mitigate the risk of needing to undertake wholesale re-design (expensive and time-consuming to run) during later design development stages to reduce the cost of the project back to within the approved budget. It forms a key part of the project controls process to monitor the cost estimate against budget.
- **Design development (value management/value engineering)** – be cautious about value management / value engineering solutions in that they may not yield the identified performance and benefits to deliver the required cost savings.
- **Design development (design management)** – the approach to design management must be detailed, and skilled resources (both internal and external) must be identified and secured to deliver the design for projects of scale and complexity.

Key Lessons Identified

The key observations, lessons and actions taken are listed in the table below:

Lesson Category	Observations	Learning	Current actions / future actions
Governance	There have been constant changes to governance throughout the life of the NDH project. These have directly impacted on the project team in terms of delayed decisions, relitigating of key issues and scope. Issues around governance, decision-making and delegations are well-canvassed in Gateway Review documents and in advice to Joint Ministers.	The NDH project should have been established as a programme business case covering all key interrelated components and dependencies (construction, service transformation and digital infrastructure). These were split between the Ministry of Health and Southern DHB with the responsibility for delivery of the benefits sitting primarily with Southern DHB. The advent of Health NZ and Te Akai Whai Ora offers the opportunity to: • Take a whole-of-life planning and health system-wide perspective. For example, delivering more digitally-enabled health care in the community may be effective in enabling a smaller hospital to be built but requires model of care change and digital investment. Choices and trade-offs across all three workstreams are required to achieve optimal outcomes. • Improve local investment decisions (informed by better national and regional service planning).	The Health NZ infrastructure governance model for major projects has been re-set for both the New Dunedin Hospital as well as upcoming major projects. It comprises: • The Capital and Infrastructure Committee that assists the Board to oversee and monitor capital spending and infrastructure delivery for facilities, clinical equipment and digital systems • A standardised Infrastructure Programme and Project Governance Framework that will ensure project roles and structures are established consistently and appropriately depending on the value, risk and complexity of the project. Terms of Reference for Project Steering Groups and Project Sponsor for major projects (high-value and/or high-risk) accompanied with governance guidance has been drafted. It recommends that membership of governance boards be kept to manageable levels to achieve more strategic and focussed governance oversight. The terms and guidance material are currently out for consultation with Te Aka Whai Ora.

Lesson Category	Observations	Learning	Current actions / future actions
		• Improve the governance of all major projects being delivered within the overall health infrastructure pipeline.	
Investment and business cases (scope)	A number of scope and funding issues arose subsequent to the Indicative Business Case that took considerable time to work through, examples being: • Funding of the Interprofessional Learning Centre (partial funding only and not within scope of project). • Expectations around Green Star rating (what level) and longevity (50 years/100 years) of the buildings. • Scope and authority for Land Purchases. • Location of the Primary Birthing unit, and whether to remain in scope or locate elsewhere. • Availability / allowance for teaching spaces within the hospital. • Outstanding decisions on scope, cost and funding for a digital hospital. • Sufficiency of car parking allowance.	Project scope inclusions and exclusions must be detailed at the outset to achieve a clear definition and understanding of project scope. This will enable these to be appropriately managed and priced. Be careful to identify and articulate sources of funding, especially if there is any expectation that it will come from other Votes or entities. This equally applies to the operating model (and costs thereof) where multiple partners are to deliver the scope. Consider resubmitting business cases for material scope changes that impact on the original options analysis and funding envelope. Define strategy around Green Star and sustainability (and clear articulation of benefits/outcomes/cost savings) as part of the business case planning process to assess cost impacts and to allow for informed decision-making by the requisite authority holders.	Work is well progressed to develop a business case handbook that offers a proven methodology and framework for thinking about the development, approval, procurement and delivery of programme and project proposals. The handbook will also provide: • A structured format to allow an organisation to develop standardised proposals and explain and justify any particular project or programme. • A tool to enable an approving body to decide whether or not to allow a project or programme to go forward. • An overall process for the scoping and planning of government health investments. • An evidence-based audit trail to assist transparent decision-making. Sustainability accreditations are included in the recently issued New Zealand Facility Design Guidance Note.

Lesson Category	Observations	Learning	Current actions / future actions
	• Dairy building refurbishment – funding to make good and whether in scope of project.		
Investment and business cases (all workstreams)	The original business case process for the New Dunedin Hospital Building ignored the digital infrastructure and solution requirements, necessitating a separate business case process.	Digital infrastructure and foundational work to adapt existing solutions is a key dependency (the new hospital buildings cannot operate without this investment) and it should either be included in the hospital business case, or the business case should be developed alongside, so that business case approvers understand the full commitment required in order to build and open the new hospital buildings.	The business cases prepared for the Whangarei project includes the construction and digital transformation enabler, but not the service transformation. However, the Nelson Business Case will include the three workstreams: (construction, service transformation and digital infrastructure). The business case handbook will also require all three workstreams to be captured as part of the investment decision.
Investment and business cases (major health system changes)	The NDH digital transformation business case met the needs and expectations of the previous Southern DHB at that time (a Southern health system digital transformation). However, as the reforms were to come into effect within six months of Southern DHB approving the business case, in hindsight, requesting the minimum required to maintain progress on the hospital build and seeking permission from new governors to develop a	Business cases being submitted for approval in the midst of major system change should ask for minimum requirements to enable progress to be made and propose a future stage for more aspirational, transforming investment.	This situation is now void with the advent of Health NZ and the requirement that all significant investments over $25 million be submitted to the Health NZ Board for approval and/or endorsement prior to Ministerial and/or Cabinet approval.

Lesson Category	Observations	Learning	Current actions / future actions
	supplementary, more transformational case for further investment would have been the most prudent way to address the change in governors and decision makers, given the future unknowns at the time the business case was approved by the existing Southern DHB.		
Investment and business cases (Scope)	The project owner (Ministry of Health) could not clearly answer in-scope / out-of-scope activities that formed the project's scope. The NDH project scope began as a single building (Clinical Services Building) replacement. As the complexities of this integration into other existing buildings became clear, it turned into a full hospital replacement. The engagement with users at this time encouraged "blue-sky" thinking that set unrealistic expectations and stretched the project budget beyond its original indicative estimate. This has required several reviews of scope over and above what could be considered normal practice in a large-scale project.	Clearly define infrastructure in-scope and out-of-scope services / functions at the outset and ensure that the rationale is well understood by – and, where possible, agreed with – the various stakeholders. Clearly set out and agree the process, methodology and data inputs (benchmark data, clinical services plan) to help define the infrastructure scope in a managed and structured manner.	This is being addressed in the business case handbook.
Project Planning (Master	A programme re-set was needed in October 2018 as milestone dates for delivery of the hospital in the Indicative Business Case were deemed to be unrealistic (originally to be commissioned by February 2027). The approach and timing of	Continually test the programme with subject-matter experts, including from the construction industry, as part of each business case planning process. Document all key assumptions underpinning the programme.	The Project Delivery Framework update to reflect the requirements around master programme development, management and assurance.

Lesson Category	Observations	Learning	Current actions / future actions
	delivery changed (staged to deliver Outpatient Building first).	Be clear in articulating and managing stakeholder expectations around the level of accuracy and certainty of information contained in business cases and the consequences depending on the accuracy /certainty levels. E.g. such as milestones and budget – time lags between the Indicative and Detailed Business Cases can have a considerable impact on these.	
Planning/ Stakeholder Engagement	A key delivery risk identified early in the process was finding the necessary resources (from labourers to skilled site leaders and contractors) to build the hospital because of its location and proximity to the labour market. The NDH project became a catalyst in the establishment of a construction-based Jobs and Skills Hub managed by Workforce Central Dunedin (WFCD). WFCD is a collaborative Community, Government and Industry approach that will help grow the local construction workforce. WFCD aims to upskill and provide employment to more than 300 local people onto the hospital build and has a target to induct and upskill over 900 workers on the site, which will help mitigate the impact that skill shortages could have on the programme.	WFCD has been successful to date due to it securing specific funding of $1.85 million over four years from Provincial Growth Fund, in support of the NDH Project. Commitment and funding avenues to support such initiatives for large scale projects should be explored as part of the business case process. WFCD has made effective use of the long lead time to deliver the hospital by identifying skill shortages within certain trades for hospital delivery and partnering with local businesses to identify and train candidates. An example of this is hospital vinyl layers: three local commercial flooring companies agreed to take on trainees.	These learnings from WFCD have been reflected in the Portfolio Level Infrastructure Broader Outcomes Strategy, and specifically included as a case study for future reference by projects.

Lesson Category	Observations	Learning	Current actions / future actions
		The WFCD created a template that can be tailored for other projects or industries to attract new trainees, employers and apprentices.	
RAID - Risks/Assumptions/Issues/Dependencies (Geotechnical issues, Commercial risks)	Risks and issues pertaining to the land acquisition programme design impacts not well considered. The site was selected after the Indicative Business Case and, in the absence of a Site Masterplan, there was uncertainty as to how much land would be required. Once a new central city site was selected, the project was put on notice that land conditions were generally poor (estuary/contaminated fills/sand) requiring further and detailed investigative works to test the soil profile of the two sites to determine the viability of the placement of the buildings during site master planning and to inform the foundation strategy. These geotechnical issues led to a significant level of uncertainty throughout the early design stages, and the in-ground risk transfer presented as significant risk from a contractual perspective.	Plan for thorough due diligence before land purchasing decisions are made. Noting that any detailed investigation may be constrained / delayed if existing structures are on site. Allow (or hold float) for this activity in the programme. Prepare a land acquisition strategy / plan to formalise the process, consenting approach and any investigative work requirements for approval by governance and approved decision makers.	The Project Delivery Framework update to reflect the due diligence requirements and documentation requirements in regard to land purchases.

Lesson Category	Observations	Learning	Current actions / future actions
Schedule of Accommodation (Scope Creep)	Significant growth in area sizes between Indicative Business Case (IBC) and site master planning (over 9,000 m^2). This meant that elemental cost estimate based on the Preliminary Site Masterplan Report showed a project indicative cost in the order of $1.5 billion (against IBC estimate of $1.2 – $1.4 billion). A number of areas needed further investigation and challenge, but Quantity Surveyor cautioned that it would be difficult to bring this cost below $1.4 billion.	Establish comprehensive design standards for New Zealand hospitals. Avoid "users" dictating the size of rooms. Rather, clinical user feedback should be about function and how they wish to work in the future. Be cognisant of how services will be delivered in future as this can lead to over-estimation of spaces. Commission Independent Review of the Schedule of Accommodation (SOA) early in the process and make allowance for this in the programme. This review should rigorously: • Test the validity of assumptions underpinning the SOA space allocations. • Test the SOA against Australasian Health Guidelines for area sizes with reference to the Models of Care in the Functional Brief, with any exceptions and rationale to be clearly documented and approved by the requisite authority holders. • Identify potential opportunities for collaborative and connected service delivery (especially if services delivered from multiple buildings).	A key deliverable of the Design and Facilities Team within the Infrastructure and Investment Group is to lead the development of standardised design for health facilities. For instance, in September 2022 the New Zealand Facility Design Guidance Note was published and is available on Health NZ's website. This guidance reinforces the Australasian Health Facility Guidance as the primary reference guide to briefing and designing health facilities in New Zealand. Supplementary guidance is provided for New Zealand-specific design requirements, and this will continue to evolve as design policy positions are taken. The IIG has developed the Design Guidance and Assurance Framework that sets out objectives and processes for developing and implementing design guidance, including assurance processes to support implementation.

Lesson Category	Observations	Learning	Current actions / future actions
		• Test basic arithmetic and calculations in the SOA. Commission independent review of cost estimates and depending on complexity / scale of project, consider use of independent parallel estimates.	
Services Planning (Demand and Capacity Modelling)	The national policy statements on demand and capacity modelling were unclear (or unavailable) during formative design phases, e.g. how many ICU beds should be supplied based on nationwide strategy and direction. The project found that data used in the modelling was not of uniform quality and was often disputed by both clinicians and decision-makers.	Agree a national position on capacity within key capacity elements, such as overnight beds, and theatres, to direct design decisions. For instance, Health NZ strategic policy statements, overarching functional principles on demand/capacity modelling for overnight beds and priority services models. This should be the starting point of any service capacity planning, with any exceptions to this being independently validated. The quality, integrity and uniformity of the data across functional areas should be tested and benchmarked nationally to support effective investment decision-making and prioritisation of the health infrastructure pipeline.	Develop national and regional service planning and standardised models of care to ensure that right sized infrastructure investment is made in the right location and at the right time.

Lesson Category	Observations	Learning	Current actions / future actions
Stakeholder / User Engagement	The NDH project faced logistical and engagement issues in running user groups to inform the design development. Some of the issues related to the clinical bandwidth to ensure efficient and effective user engagement by having the right people involved consistently through the engagement process. Some issues related to a lack of clarity about the scope and questions being asked. Some issues related to the need to repeat design phases due to changes in design direction. Overall, and despite some initial nervousness, the design team agreed that user input was valuable and enhanced the outcome.	There are opportunities for streamlining the stakeholder / user engagement process by adopting Health NZ's national strategic policy directives / overreaching functional principles and a standardised approach to services planning across the health network. Be clear to maximise the value add contributed by stakeholders/users and the objectives of the engagement. The objective is to work in partnership with the design team and the project team to guide the design development to ensure it is fit for purpose operationally and clinically – the primary focus should be on functionality and patient flows. Clearly set out and communicate expectations around the design process where multiple and influential stakeholders / users are involved. Bring stakeholders / users on a journey from the start and right through to operational commissioning and change management. Avoid re-litigation of previously agreed design due to changes in key leadership and governance roles.	The Project Delivery Framework update to consider supplementary information around approach to stakeholder / user engagement and processes thereof.

Lesson Category	Observations	Learning	Current actions / future actions
		Undertake cultural narrative planning and iwi consultation early in the planning process to ensure projects are best positioned to meet equity considerations.	
Commercial/Procurement	The procurement of the design teams disciplines started in 2018 but needed to be cancelled and restarted due to concerns around probity / and completeness and accuracy of the scope of works being tendered. This meant that procurement of the design team disciplines did not commence until February 2019 with RFPs closing end of March 2019. The Design Team was not mobilised until mid-2019 (being a considerable delay against the original master programme).	Use experts familiar in both government and infrastructure procurement processes to mitigate against any procurement process / probity risks for projects of scale and complexity. Use experts to review / standardise scope of works for all design disciplines. Take lessons from prior hospital builds like Burwood, Waipapa, and Christchurch Outpatients Building. These are critical inputs to improving the quality of tender documents and efficiency of procurement processes.	The Infrastructure and Investment Group has: • Rolled out standardised procurement templates and tools that capture best practice for use by project teams. • Sourced both internal and external resource with the necessary procurement experience and skills to assist with complex and high-risk procurements. • Engaged a Probity Auditor (independent) and Probity Advisor (advisory) for major infrastructure projects. Work is underway with subject matter experts to develop a set of standardised design consultant team scope of services. This will help to describe health services in a common and consistent way to the market.
Design Development	Upon design team appointments, a further Concept Design re-set was required to deliver a design within affordable funding (budget target of $1.3 billion).	Consider independent advice and guidance on critical design and construction issues for projects facing significant buildability, complexity, cost and programme challenges to	The IIG has developed the Design Guidance and Assurance Framework that sets out objectives and processes for developing and implementing

Lesson Category	Observations	Learning	Current actions / future actions
		support the project team and ensure that the fiscal consequences of design decisions are well understood. Be clear as to any infrastructure level design assurance policies and practices. Prepare Design Features Report as part of the Concept Design briefing to go along with the Site Masterplan, design principles and project objectives. By way of example, this would include: • importance level for each building / element • design life for each building • low-damage design criteria • future flexibility /adaptability requirements • environmentally Sustainable Design aspirations, durability / sustainability requirements • digital hospital requirements • minimum design standards and benchmarks. Be clear as to operational / facility inputs into the design development process. For example, Emergency Response Plans for hospitals and services provision as they need to be assessed	design guidance, including assurance processes to support implementation.

Lesson Category	Observations	Learning	Current actions / future actions
		in order to be reflected in the planning and design development process as early as possible.	
Design Management (Value Management /Value Engineering)	Several iterations of the value management / value engineering activity had to be undertaken due to COVID and adverse global market conditions (increased material costs / supply constraints) resulting in a significant increase in forecast project costs over and above project costs originally envisaged in the approved detailed business case.	Be cautious about value management / value engineering solutions in that they may not yield the identified performance and benefits or deliver the required cost savings. They potentially may cost more in the longer term, particularly considering the enhanced risk of degrading project element specifications to reduce initial cost, with the unintended consequence of increased cost over the life of the facility.	The Project Delivery Framework to identify and address any value management / value engineering process, review control points and documentation requirements. The Project Delivery Framework to consider supplementary information on establishing a Design Management Framework for use of infrastructure projects.
Design Development (Value Management/Value	The value management / value engineering process was drawn-out potentially leading to savings being lost and time impacts.	Ensure that the approach to value management / value engineering is documented and programmed to be completed promptly (expensive and time-consuming to run) for each design stage and that the objectives are well understood, or value management initiative cost saving benefits may be eroded by time-related costs due to project prolongation caused by the time to conduct value management and re-documentation.	The Project Delivery Framework to identify and address any value management / value engineering process, review control points and documentation requirements.

Lesson Category	Observations	Learning	Current actions / future actions
		It is advised that during the later stages of the design, the focus should be on optimising or tweaking the design (lowering costs without loss of performance or function) rather than making wholesale design changes to bring the design back within budget, otherwise there is significant design co-ordination risk between architectural, building services and structural elements in particular. *(Continued below)*	
		Ensure that the right people from the business are involved in making decisions to facilitate the subsequent approval of changes in a timely basis by the requisite authority holders. It is most important that any change to design provides a benefit in either service delivery or cost savings that is greater than the cost of the change, including calculated additional risk.	

Lesson Category	Observations	Learning	Current actions / future actions
Design Development (Design	The Request for Proposal to secure independent design management services to support and manage the NDH Design did not attract the right providers (design professionals) to meet the project's expectations around the management, coordination and control of the design for a project of this scale and complexity.	Consider in detail how design management should be delivered and select the appropriate skilled resources to deliver it with clear expectations and lines of authority.	Design management consultant scope of works is under development.

Aide-Mémoire

Draft Cabinet Paper: New Dunedin Hospital – Cost Pressure Funding

To:	Hon Dr Shane Reti, Minister of Health	**Reference:**	HNZ00038094
From:	Jeremy Holman, Chief Infrastructure & Investment Office	**Due Date:**	27 February 2024
Copy to:		**Security level:**	Budget - Sensitive

Contact for telephone discussion (if required)			
Name	**Position**	**Telephone**	**1st contact**
Jeremy Holman	Chief Infrastructure & Investment Office	s9(2)(a)	x
Monique Fouwler	Interim Head of Infrastructure Delivery	s9(2)(a)	

The following departments/agencies have been consulted

Attachments	Appendix 1: Talking Points

Draft Cabinet Paper: New Dunedin Hospital – Cost Pressure Funding

Purpose

1. This Aide-Mémoire provides you with the draft Cabinet paper: *New Dunedin Hospital – cost pressure funding* and talking points (Appendix 1) for Cabinet on 11 March 2024.

Background

2. On 9 February we provided you the briefing Draft Cabinet Paper: New Dunedin Hospital Cost Pressure Funding and options [HNZ00037416], attaching a draft Cabinet paper, seeking Cabinet agreement to immediately fund cost pressures faced by New Dunedin Hospital (NDH).
3. The draft paper has been shared with the Ministry of Health, Treasury and the Infrastructure Commission. Their feedback has been incorporated.

Funding NDH cost pressures through the DB Equity Support Capital Contingency

4. That briefing sought your agreement to one of two options for funding of the cost pressures by rephasing funding from the Health Capital Envelope (HCE). You subsequently sought additional options.
5. We understand your preferred option is to reallocate $290 million from the 'DHB Equity Support Capital Contingency' to meet the cost pressures faced by NDH.
6. The DHB Equity Support Capital Contingency was set up in Budget 2020 [CAB-20-MIN-0155 refers] and has a balance of s9(2)(b)(ii), 9(2)(j) . This contingency provided us with equity support to cover any future deficit, including any further revisions in Holiday's Act remediation payments. Advice from the Ministry of Health is that we do not need any further equity support and this funding can therefore be reallocated to meet NDH cost pressures.
7. The draft Cabinet paper reflects this proposal. If Cabinet agrees to the proposal, funding will be held in a tagged capital contingency until drawdown is required. The drawdown of the Capital contingency will be subject to us completing an Implementation Business Case and this being approved by Cabinet.

Next steps

8. The Cabinet paper will be lodged with Cabinet Office on 29 February 2024. It will be considered by the Cabinet 100-Day Plan Committee on 5 March 2024 prior to Cabinet consideration on 11 March 2024.

Appendix 1 provides you with talking points to accompany the draft Cabinet paper.

Appendix 1 – Talking Points

- s9(2)(g)(i)
- s9(2)(b)(ii), 9(2)(g)(i), 9(2)(j)
- s9(2)(b)(ii), 9(2)(g)(i), 9(2)(j)
- s9(2)(g)(i)
- s9(2)(g)(i)
- s9(2)(b)(ii), 9(2)(g)(i), 9(2)(j)
- s9(2)(b)(ii), 9(2)(g)(i), 9(2)(j)
- s9(2)(b)(ii), 9(2)(g)(i), 9(2)(j)
- s9(2)(b)(ii), 9(2)(g)(i), 9(2)(j)
- s9(2)(g)(i) .
- s9(2)(g)(i)

Additional points if required

NDH rationale

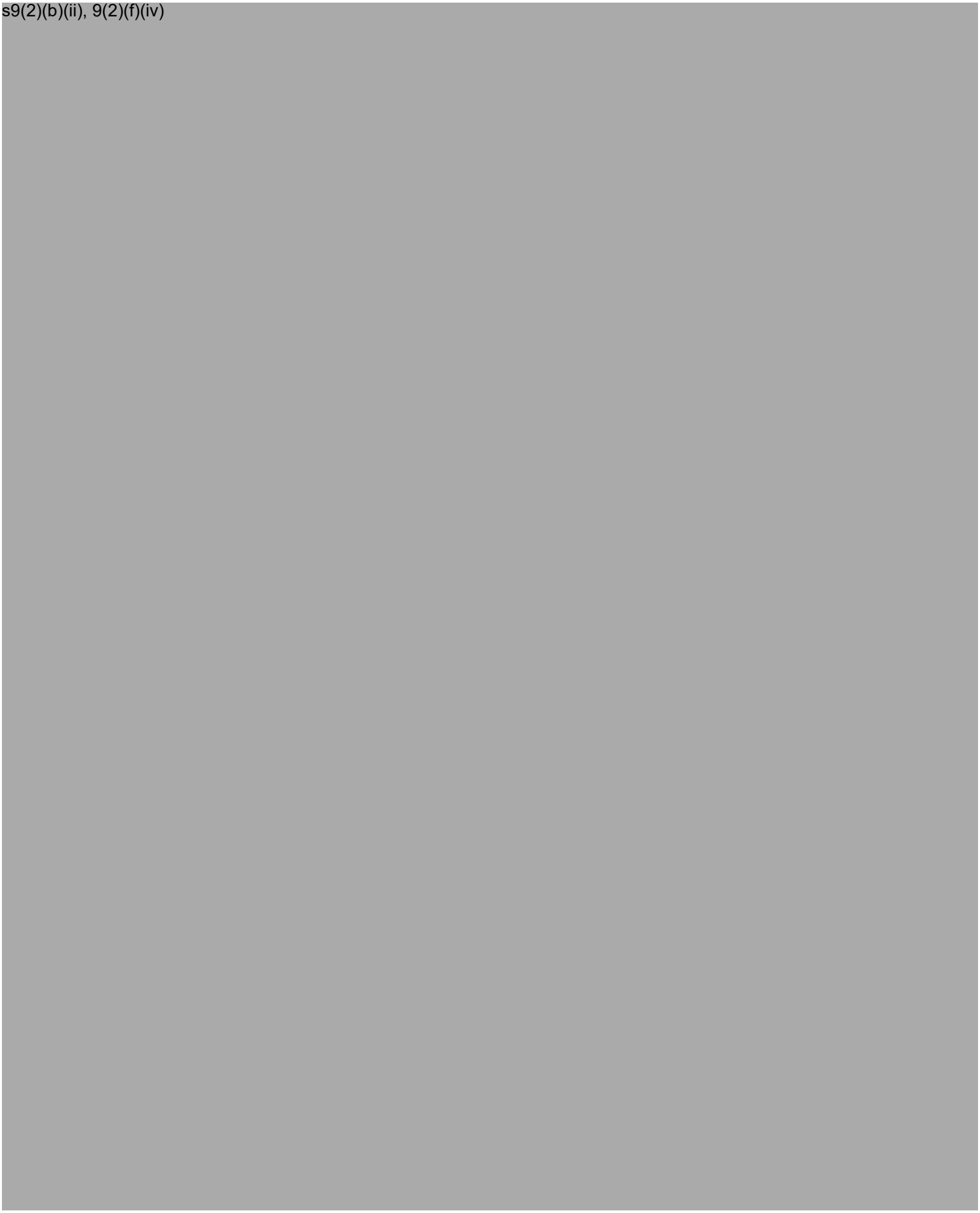
- NDH is intended to address:
    - A deteriorating environment that is eroding quality of care, creating safety risks and potential harm, causing distress to patients and staff.
    - Inflexible and inappropriate care facilities restricting service capacity, causing delays and increasing outsourcing costs.
    - Care facilities cannot absorb innovations, preventing efficiency gains and care improvements.
- Current design of the NDH Inpatient building will add 43 additional beds, 9 additional theatres, 22 ED bays, 9 imaging suits, 2 birthing rooms and 3 maternity assessment units, as well as various additional clinical and consult rooms also planned.

s9(2)(b)(ii), 9(2)(j)

- [redacted]

Further points on the following page

s9(2)(b)(ii), 9(2)(f)(iv)



- s9(2)(b)(ii), 9(2)(f)(iv), 9(2)(j)

Future decisions in the Health Capital Portfolio

- Establishing HNZ has allowed us to build a national view and has significantly strengthened governance, planning and implementation for capital projects.
- I have confidence that we can avoid similar planning and delivery shortcomings.
- I intend to come back to Cabinet in July 2024 on how best to proceed with the health capital pipeline and future funding decisions based on HNZ's prioritisation work.

s9(2)(b)(ii), 9(2)(j)

New Dunedin Hospital Assurance

Health New Zealand
Te Whatu Ora

Governance Structures and Processes Health New Zealand already has in place

Process	Description	How does this help
Building internal capability	• In May 2022, a new programme director was introduced s(9)(2)(a), s9(2)(g)(i) • HNZ has appointed a new Head of Infrastructure Delivery and a Head of Infrastructure Commercial & Procurement. HNZ will continue to bring critical delivery leadership and commercial roles in house.	• Less reliance on external contractors/consultants • Ensures HNZ has the internal capability to successfully manage the projects it owns.
Project Steering Group	• The Project Steering Group oversees the NDH project. It monitors, challenges, advises and supports the Independent Chair in fulfilling their role. This includes endorsement of key project documents and project decisions.	• The Project Steering Group ensures that NDH is delivered to schedule, meets its objectives, delivers the projected outcomes and is on track to realise the required benefits within the approved budgets. • The Chair, Tony Lanigan brings over 10 years' experience in the governance of major health infrastructure projects. • The Treasury, Ministry of Health and Infrastructure Commission bring their expertise as observers.
Senior Responsible Officer (SRO)	• Health NZ is in the process of appointing a new SRO. The current acting SRO (Dr Tony Lanigan) will stay in his formal role as an independent board member with a focus on the engineering and construction risks of the project.	• The new SRO will have significant health and community engagement experience and an understanding of the regional challenges. • This will be combined with Dr Lanigan's experience to allow the project board to govern to scope and budget as we move out of design and into execution, managing clinical and stakeholder risks alongside engineering.
Capital and Infrastructure Committee	• The Committee has a variety of duties in relation to overseeing and monitoring capital spending and infrastructure delivery across the health system. This includes overseeing the delivery of major infrastructure projects.	• The Committee Chair is Naomi Ferguson and members include Dame Karen Poutasi, Hon. Amy Adams, Lale Ieremia, Mei Fern Johnston, and Scott Pritchard, represent a strong mix of independent industry expertise as well as Board members. • The Committee are consulted with on all issues regarding NDH. This includes a regular 'deep dive' into the issues.
Regular reporting to Ministers	• Each month the Minister of Health received reporting on our Infrastructure portfolio. This includes an update on the progress of the NDH and any issues arising.	• The report includes an update on the RAG status of the project and provide updates on cost, scope, timing and whether the current funding is sufficient. This reporting is also shared with the Ministry of Health in their monitoring role. • The project reporting should highlight how the project is performing and indicate where additional review or assurance may be needed to maintain confidence in delivery.
Gateway Reviews and Independent Quality Assurance (IQAs)	• As NDH is a major project, Health NZ has undertaken a number of Gateway reviews and IQAs at key stages of the NDH projects. • Governance of the NDH has been strengthened in February 2021 following Gateway review and January 2023 following an Infrastructure Commission review. • Health NZ will also have a Gateway review later this year to inform the Implementation Business Case.	• Gateway is an independent peer-review process led by The Treasury, that examines investments at key points in their life cycle to assess their progress and to rate the likelihood of successful delivery of their outcomes. • Gateway reviews are confidential to the SRO. However, if they receive a red/orange or a red/red rating then the Minister of Health and Minister of Finance will get a copy.
Risk and assurance function	• Health NZ is setting up an enterprise level risk and assurance function and a risk and assurance function within the Infrastructure and Investment Group.	• The risk and assurance functions will support the development of overarching strategies and plans. This will ensure that the right level of risk management and assurance activities are undertaken at the right time across Health NZ national and regional functions, as well as key projects within the Infrastructure portfolio. • They will provide training and support to members of the governance boards, identify and appoint SROs, review advice and advise on risk areas and assurance requirements.