In Confidence

Office of the Minister of Health

Cabinet

New Dunedin Hospital – Cost pressure funding

Purpose

1. This paper seeks Cabinet's agreement to cover cost pressures associated with the New Dunedin Hospital (NDH) project through immediate re-allocation of $290m from the DHB Equity Support Capital Contingency. This is to ensure that the project can be delivered to the currently agreed scope and timelines.

Relation to government priorities

2. The proposal in this paper will enable Health New Zealand (HNZ) to provide essential health services to the Dunedin and wider Southern district, aligning with the Government's priority to deliver effective and fiscally sustainable public services.

Executive Summary

3. The NDH project is currently the largest vertical infrastructure project in New Zealand. NDH is at a critical juncture in its delivery. The outpatient building is already under construction and will be operational in late 2026. s9(2)(b)(ii), 9(2)(j) the inpatient building due to be complete in mid-2029.

4. The project is facing cost pressures due to construction cost inflation and risks identified through ongoing design work.

5. I am seeking your agreement to immediately re-allocate $290 million from the DHB Equity Support Capital Contingency. This contingency [CAB-20-MIN-0155] currently has a balance of s9(2)(b)(ii), 9(2)(j) to provide HNZ equity support to cover any future deficits, including any further revisions in Holidays Act remediation payments. Officials are confident that HNZ does not need further equity support to cover any future deficits if sufficient funding is provided to meet cost pressures. This funding can therefore be reprioritised for NDH.

6. The $290 million will cover immediate funding requirements for entering into a contract with the preferred contractor and the estimated contingency requirements for completion of the inpatient building based on a January 2024 independent quantity surveyor estimate. The re-allocation will prevent further delay (which would have cost and service delivery implications) and allow the project to be completed to the agreed scope and timeline.

7. HNZ has not yet completed the Implementation Business Case for the Inpatient Building, which would provide more information to support its recommended contracting approach and how risks will be managed. I expect an interim Implementation Business Case to be approved by me and the Infrastructure and Investment Ministers (the Ministers of Finance, Infrastructure, Regional

Development) prior to contract signing to provide assurance that effective governance is in place and that key commercial terms are conveyed and understood. The interim Implementation Business Case will be supported by a targeted review of project status and readiness to contract led by an independent expert, facilitated by Te Waihanga, with support from the Treasury and the Ministry of Health, undertaken by an independent expert.

8. The Infrastructure and Investment Ministers and I have also agreed to the following additional assurance requirements, based on key points in the project, to add capability and/or improve communication between Ministers and the Board:

   8.1. appointment of a Crown observer specific to the NDH project, to have line of sight on decision making and assurance discussions relating to the project, from the NDH project steering group, through the HNZ Capital and Infrastructure Committee and to the HNZ Board for all matters relating to the NDH project.

   8.2. requiring the NDH project to report to the Infrastructure and Investment Ministers' Group.

9. The $290 million will be held in a tagged contingency subject to Cabinet approval of a final Implementation Business Case for NDH that is informed by a Gateway review, a quantitative risk assessment, and further developed design and costing estimates worked through with the preferred contractor (CPB). s9(2)(b)(ii), 9(2)(j) [redacted]

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

11. Governance changes and cost savings measures have been implemented to support effective delivery of NDH. Strengthened governance and management structures have been instrumental for the NDH project, the risks and issues it is facing, and how HNZ will improve how the health capital portfolio is managed in the future.

12. I have also directed HNZ to provide Joint Ministers with enhanced monthly reporting on NDH and have commissioned a one-off independent review of lessons learned from the NDH project by HNZ and the Ministry of Health, to be led by an independent expert.

13. HNZ provided me with a long-term Infrastructure Investment Plan (IIP) and a National Asset Management Strategy setting out a nationally prioritised pipeline of investments. These are the first dedicated nationwide strategic plans specifically for health infrastructure. I intend to come back to Cabinet later in 2024 on how to proceed with the pipeline outlined in the IIP and options for funding it in the medium to long term.

Background

14. The NDH project is currently the largest vertical infrastructure project in New Zealand. The NDH detailed business case and $1.47 billion was approved by Cabinet in April 2021 [CAB-21-MIN-0124]. An additional $110 million was approved in December 2022 and $10 million in April 2023. A total of $1.59 billion is appropriated for the project, plus a Data and Digital tagged contingency of $225 million (of which $68 million has been drawn down).

15. NDH is at a critical juncture in the programme. The outpatient building is under construction and will be operational in late 2026 s9(2)(b)(ii), 9(2)(j) project is facing cost pressures due to trade pricing, ongoing inflation and exchange risk, design risk and sub-contractor risk, in combination with complexity and location risk. s9(2)(b)(ii), 9(2)(j)

16. NDH was originally being delivered by the Ministry of Health and planned under historic arrangements led out of the former District Health Boards. The bespoke governance arrangements were not strongly accountable to national health and capital outcomes which was representative of historic planning and costing approaches.

17. Specifically, the legacy decisions made that have caused the current and ongoing cost pressures and transferred the risk to HNZ relate to:

    17.1. **Poor site selection** – cost premiums associated with land acquisition and demolition costs, contamination and flood level risk. The alternative location at Wakari Campus would have avoided significant land acquisition, demolition, ground preparation and flood risk costs.

    17.2. **Building footprint** –building two buildings, rather than one as was planned.

    17.3. **Fast Track programme** – s9(2)(g)(i)

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

18. The NDH project was due to provide an Implementation Business Case to Joint Ministers in December 2023. s9(2)(b)(ii), 9(2)(j) the project was being delivered by the Ministry of Health. The project is now being delivered by HNZ.

19. The Implementation Business Case is a short document that revisits and confirms key details of the Inpatient Building, identifies the supplier offer that optimises value for money, and sets out the negotiated commercial and contractual arrangements for procurement (albeit less informative for an early contractor engagement and managing

contractor arrangement). It is a further assurance step to support the HNZ Board to set out its proposed way forward and to communicate its assumptions.

20. HNZ has presented advice to Joint Ministers, including information about the strategic and commercial management for investment in NDH, risk management and affordability. On this basis, Joint Ministers have agreed to progress cost pressure funding decision to Cabinet.

21. Governance changes and cost savings measures have been implemented over time to support effective delivery of NDH. Establishing HNZ, and its Infrastructure and Investment function has strengthened how major health capital projects are implemented. I also expect HNZ to continue to improve how business cases for new investment in the health portfolio are developed and presented for decisions.

Proposal to Fund New Dunedin Hospital Cost Pressures

22. I am seeking your agreement to immediate re-allocation of $290 million from the DHB Equity Support Capital Contingency. s9(2)(b)(ii), 9(2)(j)

23. The $290 million total is consistent with up-to-date cost pressure estimates. In January 2024, HNZ sought a full cost review for the inpatient building which indicated the cost pressure to be $290 million. s9(2)(b)(ii), 9(2)(j)

24. There is a risk that further cost increases will occur as design is progressed and the further pricing is received from the contractor. Any further cost increases will be reflected in the final Implementation Business Case, informed by a quantitative risk assessment. To mitigate this risk, I propose that the funding will be reserved in a tagged contingency, to be released upon Cabinet approval of a final Implementation Business Case to Cabinet.

25. s9(2)(b)(ii)

26. Without re-allocation, the NDH project would not be able to proceed to the agreed scope and timeline and there would be further delay to the provision of essential health services to Dunedin and the wider Southern district.

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

    27.1. s9(2)(b)(ii)

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

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

Other options considered

28. I also considered:

28.1. seeking additional Crown Capital funding as a pre-commitment ahead of Budget 2024 decisions.

28.2. utilising underspends and the reprioritisation of other available health capital contingencies.

28.3. rephasing funding from the Health Capital Envelope (HCE).

29. Providing additional Crown Capital funding as a pre-commitment ahead of Budget 24 would enable projects in the health capital pipeline to continue as per agreed scopes and timeframes. However, a funding decision considered outside of the usual Budget process would be at the risk of misalignment to Government priorities.

30. There is not currently sufficient underspend and available health capital contingencies to meet NDH cost pressures without impacting on funding of other health capital priorities.

31. Rephasing committed funding in the HCE would constrain the ability of HNZ to support other projects and would require a significant uplift in future funding due to cost escalation to deliver those projects affected. If funds were not replaced in the HCE via Budget 24 it would result in further delays and potential cost increases to deliver the planned level of services across the health capital portfolio.

Future funding requirements

32. Completion of NDH is planned for 2028/29 s9(2)(b)(ii), 9(2)(j) [redacted] following additional items s9(2)(b)(ii), 9(2)(j) [redacted] that are not part of the original NDH business case, but are important to project completion:

32.1. Pathology laboratory development (approx. $45 million required by 2025).

32.2. Additional carparking beyond the currently agreed s9(2)(j) [redacted].

32.3. Reuse/decommissioning buildings at former hospital site (approx. $325 million required by 2029).

33. s9(2)(j) [redacted]

A pending decision on the appointment of the main contractor

34. CPB Contractors were procured as the Early Contractor Engagement (ECE) contractor via a competitive tender process s9(2)(b)(ii), 9(2)(j)

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

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

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

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

39. The proposed approach and risk mitigations will be outlined in the Implementation Business Case.

Project governance and accountability

40. An Implementation Business case will be completed to provide assurance that effective governance is in place and that key commercial terms are conveyed and understood by myself as the Minister responsible for the NDH project. s9(2)(b)(ii), 9(2)(j)

41. HNZ have confirmed that the project's governance follows the Infrastructure Commission's guidance on major project governance and previous Treasury Gateway Review recommendations. Augmenting the project steering group, HNZ's Capital and Infrastructure Committee (which includes three Board members (Dame Karen Poutasi, Naomi Ferguson and Hon. Amy Adams) and three independent expert advisors)

oversees and advises the Board on risks and issues for major HNZ projects, including NDH.

42. HNZ currently provide me monthly reporting on the health capital portfolio, including updates on NDH. I have directed HNZ to report to joint Ministers with monthly project reporting, including cost estimates based on the independent quantity surveyor report they already commission. These reports will provide updates on cost, scope, timing, risks and mitigations, whether the current funding is sufficient and progress against key project milestones.

43. I have also directed HNZ to conduct a Gateway review to inform the final Implementation Business Case. The review is intended to identify options to improve deliverability. A Gateway review examines the project at key points in its life-cycle to rate how likely a project is to achieve its intended outcomes. The outcome of the Gateway review will be shared with Cabinet alongside the final Implementation Business Case.

44. I have informed HNZ that the $290 million of funding requested through this paper, should it be agreed, will be held in a tagged contingency subject to Cabinet approval of the final Implementation Business Case.

45. Given the size and complexity of this project, Ministers and monitoring agencies need greater oversight of the NDH project, and earlier socialisation of risks as they emerge. Other Ministers and I have considered a number of options and have also agreed to the following additional assurance requirements, based on key points in the project, to add capability and/or improve communication between Ministers and the Board:

    45.1. appointment of a Crown observer specific to the NDH project, to have line of sight on decision making and assurance discussions relating to the project, from the NDH project steering group, through the HNZ Capital and Infrastructure Committee and to the HNZ Board for all matters relating to the NDH project. The Observer will provide advice to the Chair of the Capital and Infrastructure Committee, as well as directly to me as Minister of Health. I will seek approval for this appointment through the Appointment and Honours Committee.

    45.2. requiring the NDH project to report to the Infrastructure and Investment Ministers' Group.

46. The NDH project has faced several challenges, resulting in changes to scope, design and budget. It is recommended a review be undertaken to understand the causes and responses to these challenges. This will provide lessons learned for future projects. This review will be jointly undertaken by the Ministry of Health and HNZ.

Improved planning in the health capital portfolio

47. Planning and delivery of infrastructure projects has undergone noticeable change from previous DHB approaches, or when this project was being delivered by the Ministry of Health.

48. HNZ have developed capital project governance capability with strong Board representation and specialist commercial property and infrastructure advisers and have

also established a NDH project steering group. The HNZ Infrastructure and Investment Group (IIG) is building strong capital project management capability.

49. HNZ is also progressing three priority work programmes that, when completed, will form the basis of future enhancements of the health capital portfolio.

49.1. Infrastructure Operating Model – establishes an organisational structure, resourcing, systems and processes to improve efficiency and lift performance.

49.2. Infrastructure Investment Plan (IIP) – a long-term view of the relative priorities and sequencing (a pipeline) of investments in health facilities nationwide.

49.3. National Asset Management Strategy (NAMS) – focuses on improving the asset management to inform investment decisions and to maximise asset values.

50. These strengthened governance and management structures have highlighted the risks and issues the NDH project is facing, and how HNZ will improve the way health capital projects are managed in the future. I have directed that the Ministry of Health and HNZ support an independent expert-led short review of key decisions to date on the NDH project to ascertain lessons learnt for future projects.

51. HNZ provided me with the IIP and NAMS as approved by the HNZ Board in December 2023. I intend to come back to Cabinet later in 2024 on how best to proceed with the health capital pipeline outlined in the IIP and options for funding the pipeline in the medium to long term.

52. I propose to continue the existing delegations to the Ministers of Finance and I to make decisions relating to health capital investments with whole of life cost between $25 million and $100 million, [SWC-22- MIN-0063]. Decisions of greater magnitude will be referred to Cabinet.

Implementation

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

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

Cost-of-living Implications

55. This paper has no direct cost of living implications.

Financial Implications

56. Re-allocating funding from the DHB Equity Support Capital Contingency has financial implications.

57. The DHB Equity Support Capital Contingency was set up in Budget 2020 [CAB-20-MIN-0155 refers] and has a s9(2)(b)(ii), 9(2)(j) The scope of this contingency provides HNZ with equity support to cover any future deficits, including any further revisions in Holidays Act remediation payments.

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

59. Officials are confident that HNZ does not need any further equity support to cover any future deficits, if sufficient funding is provided to meet cost pressures and this funding can therefore be reprioritised for NDH.

60. The remaining balance of the DHB Equity Support Capital Contingency after this reprioritisation is s9(2)(b)(ii), 9(2)(j)

61. However, the re-allocation of funding from the DHB Equity Support Capital Contingency has a corresponding impact on the net debt. This is because this contingency was not reflected in the Treasury's 2023 Half Year Economic and Fiscal Update given the likelihood of this contingency being required was assessed as being remote at the time.

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

Legislative Implications

63. There are no legislative implications from this proposal.

Impact Analysis

Climate Implications of Policy Assessment

64. The decrease of greenhouse gas emissions is not a key policy objective for the NDH project. However, both the outpatient and inpatient building are being designed to Green Star 5 standard which ensures they meet the definition of a green building.

Population Implications

65. The NDH has been designed to meet the future needs of the Dunedin and the wider Southern district population 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.

Human Rights

66. There are no human rights implications from this proposal.

Use of external Resources

67. The NDH is a large and complex vertical infrastructure project. HNZ does not have the technical expertise internally to deliver this project. Several external consultants are involved in delivering this project, for example expert Quantity Surveyors. External resources were used for the development of the advice in this paper.

Consultation

68. The Treasury and the Ministry of Health have been consulted on this paper. Te Waihanga have been informed of the proposals in this paper.

Communications

69. If agreed, I intend to make a public announcement of this decision.

Proactive Release

70. I propose the proactive release of this paper with the appropriate redactions.

Recommendations

The Minister of Health recommends that that the Committee:

1 **note** that the Detailed Business Case of the New Dunedin Hospital (NDH) was approved by Cabinet under the previous government in April 2021 [CAB-21-MIN-0124].

2 **note** that a total of $1.59 billion has been appropriated to date for the project.

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

4 **agree** to release funding from the DHB Equity Support Capital Contingency to meet the $290 million cost pressures funding requirement faced by New Dunedin Hospital:

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

5 **agree** that the $290 million released from the DHB Equity Support Capital Contingency will be held in a separate tagged contingency for NDH subject to Cabinet approval of an Implementation Business Case for NDH.

6 **approve** the establishment of the following tagged capital contingency "New Dunedin Hospital – tagged capital contingency" to provide for the decision in recommendation 5:

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

7 **agree** the tagged capital contingency in recommendation 6 above be charged against the contingency funding released from the DHB Equity Support Capital Contingency described in recommendation 4, with a corresponding impact on the net debt.

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

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

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

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

12 **note** that I have directed HNZ to provide Joint Ministers with enhanced monthly reporting on NDH performance.

13 **note** that Ministers have agreed to the following additional assurance requirements, based on key points in the project, to add capability and/or improve communication between Ministers and the Board:

13.1 a one-off review of the NDH project, led by an external advisor and facilitated by Te Waihanga, with support from the Treasury and the Ministry of Health to be completed before the end of May 2024.

13.2 appointment of a Crown observer specific to the NDH project, to have line of sight on decision making and assurance discussions relating to the project,

from the NDH project steering group, through the HNZ Capital and Infrastructure Committee and to the HNZ Board for all matters relating to the NDH project.

13.3 requiring the NDH project to report to the Infrastructure and Investment Ministers' Group.

14 **note** that I will seek approval through the Appointments and Honours Committee for the Crown Observer, as outlined in recommendation 3.2.

15 **note** I have directed the Ministry of Health and HNZ to undertake a review, to be led by an independent expert, to ascertain lessons learned from the project to date.

16 **agree** to continue the existing delegations to the Minister of Finance and I to make decisions relating to health capital investments with whole of life cost between $25 million and $100 million, with decisions of greater magnitude being Cabinet decisions.

17 **note** that I intend to come back to Cabinet later this year on how best to proceed with the health capital pipeline outlined in HNZ's Infrastructure Investment Plan and related future funding decisions.

Authorised for lodgement.

Hon Dr Shane Reti

Minister of Health

CAB-24-MIN-0095

Cabinet

Minute of Decision

New Dunedin Hospital Cost Pressure Funding

Portfolio **Health**

On 25 March 2024, following reference from the Cabinet Economic Policy Committee, Cabinet:

1 **noted** that the previous government:

1.1 in April 2021, approved in principle the Detailed Business Case for the New Dunedin Hospital (NDH), subject to the finalisation of funding arrangements by the Ministers of Finance and Health [CAB-21-MIN-0124];

1.2 in April 2022, set new Capital Settings for Health New Zealand (HNZ), including authorising the Minister of Health to approve investments funded from within baseline with whole-of-life costs between $25 million and $100 million [SWC-22-MIN-0063];

2 **noted** that a total of $1.59 billion has been appropriated to date for the project;

3 **noted** that due to cost escalation, planning and design issues, the NDH project requires immediate additional funding of $290 million so that s9(2)(b)(ii), 9(2)(j) s9(2)(b)(ii), 9(2)(j)

4 **agreed** to release funding from the DHB Equity Support Capital Contingency to meet the $290 million cost pressures funding requirement faced by NDH:

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

5 **agreed** that the $290 million released from the DHB Equity Support Capital Contingency will be held in a separate tagged contingency for NDH, with drawdown subject to Cabinet approval of an Implementation Business Case;

6 **approved** the establishment of the "New Dunedin Hospital – tagged capital contingency" to provide for the decision in paragraph 5:

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

7 **agreed** that the tagged capital contingency above be charged against the contingency funding released from the DHB Equity Support Capital Contingency described in paragraph 4, with a corresponding impact on the net debt;

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

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

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

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

12 **noted** that the Minister of Health has directed HNZ to provide him and the Minister of Finance (joint Ministers) with enhanced monthly reporting on NDH performance;

13 **noted** that joint Ministers have agreed to the following additional assurance requirements, based on key points in the project, to add capability and/or improve communication between Ministers and the Board:

13.1 a one-off review of the NDH project, led by an external advisor and facilitated by Te Waihanga, with support from the Treasury and the Ministry of Health, to be completed before the end of May 2024;

13.2 appointment of a Specialist Ministerial Advisor to the NDH project, to:

13.2.1 have line of sight on decision making and assurance discussions relating to the project, from the NDH project steering group, through the HNZ Capital and Infrastructure Committee and to the HNZ Board for all matters relating to the NDH project;

13.2.2 report directly to the Minister of Health and the Infrastructure and Investment Ministers;

13.3 requiring the NDH project to report to the Infrastructure and Investment Ministers;

14 **authorised** the Minister of Health and the Infrastructure and Investment Ministers to appoint the Specialist Ministerial Advisor without further reference to Cabinet;

15 **noted** that the Minister of Health has directed the Ministry of Health and HNZ to undertake a review, to be led by an independent expert, to ascertain lessons learned from the project to date;

16 **authorised** joint Ministers to continue to make decisions relating to health capital investments with whole of life costs between $25 million and $100 million, with decisions of greater magnitude to be approved by Cabinet;

17 **noted** that the Minister of Health intends to report back to the Cabinet Expenditure and Regulatory Review Committee later in 2024 on how best to proceed with the health capital pipeline outlined in HNZ's Infrastructure Investment Plan and related future funding decisions.

Rachel Hayward
Secretary of the Cabinet

Event Briefing

Health New Zealand
Te Whatu Ora

New Dunedin Hospital site visit on Thursday 20 June

Due to MO:	17 June 2024	**Reference**	**HNZ00041525**
To:	Hon Dr Shane Reti, Minister of Health		
From:	Jeremy Holman, Chief Infrastructure & Investment Officer, Infrastructure and Investment Group		
Copy to:	n/a		
Security level:	**In Confidence**	**Priority**	Urgent
Consulted	n/a		

Contact for phone discussion (if required)

Name	Position	Telephone	1st contact
Blake Lepper	Head of infrastructure Delivery	S9(2)(a)	X
Andrea Birtwistle	Principal Communications Business Partner	S9(2)(a)	

Attachments

Appendix 1:	Runsheet
Appendix 2:	Biographies
Appendix 3:	Talking Points
Appendix 4:	Q&As / Reactives
Appendix 5:	History of decisions on NDH

About the event

Purpose	You are meeting with the New Dunedin Hospital (NDH) project team to view the construction site and understand what health services the hospital will provide for the people of Dunedin and the Southern region.
Date	Thursday 20 June 2024
Time	11.00am - 1.30pm
Venue	New Dunedin Hospital project office, 83 Castle Street, Central Dunedin
Expected attendees	
Health NZ representatives	• Jeremy Holman - Chief Infrastructure & Investment Officer • Hamish Brown – GDO Southern • Blake Lepper - Head of Infrastructure Delivery • Tony Lloyd - Infrastructure Programme Director • Bridget Dickson - Southern Programme Director • Professor Patrick Manning - Deputy Chair, Clinical Transformation Group • Dr Hywel Lloyd - Director Quality & Clinical Governance • Jenny Hansen - Director of Nursing • Tracy Hogarty – Director of Allied Health • Phil Baskerville – Digital Project Director • Andrew Holmes - Outpatient Project Director • Brad Marais - Inpatient Project Director • Simon Crack - Southern Deputy Programme Director • Kate Mackersy – Communications Team Leader, Southern Note: key biographies are attached as Appendix 2
Media	Media will be invited to attend the site visit (photos from a barrier by Outpatients Building). A media standup will be held following the visit.
Talking points	Please see Appendix 3.

Background

1) This event briefing provides you with information on New Dunedin Hospital Project Whakatuputupu (NDH) to support your visit to the construction site and understand progress on the project.

New Dunedin Hospital

2) The NDH is currently the largest health infrastructure build in New Zealand.

3) The NDH has faced several revisions and cost escalations. To date, $1.59 billion has been appropriated for the project. For further information on the project's decisions/costings, please see Appendix 6.

4) On 25 March 2024, Cabinet agreed to $290 million of additional funding for NDH to meet cost pressures faced by the project to:

S9(2)(b)(ii), S9(2)(j)

5) Funding will be released from the DHB Equity Support Capital Contingency on approval of the Implementation Business Case by Cabinet.

6) CPB is Health NZ's preferred contractor for the construction of the NDH Inpatient Building. CPB currently holds an early contractor engagement contract for the Inpatient Building, including earthworks and design, and the order of long lead items.

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

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

9) It is important that we do due diligence before entering into a contract for each part of the build to ensure that costs and timelines are managed prudently.

10) The NDH is being built in two stages (the Outpatient Building and the Inpatient Building).

11) The Outpatient Building is due for completion in 2026 and is solely focused on delivering planned and ambulatory care, including day procedures, pre-booked radiology scans and outpatient clinics.

    a. 75% primary steel is now up, and infill with secondary steel for the windows and the roof is starting.

    b. The white recyclable wrapping is in place for weather protection while the fire-rated paint is applied.

    c. There are around 120 workers on site each day.

d. The focus for the next few months is the paint application, preparing for the facade installation and pouring of the concrete floors.

12) The larger building, the Inpatient Building, is due to open in 2029 and will house the emergency department, operating theatres, ICU, NICU, medical and surgical wards and a midwifery-led birthing unit. It has been designed to optimise new models of care, including a surgical short stay or 23-hour unit. This unit is situated beside the theatre suite and supports patients to have care in hospital for up to 23 hours following a procedure. This approach enhances the current day surgery model of care and provides an additional level of care between day surgery and being admitted to a standard ward bed.

a. On this site, around 60% of piles have been driven to their final depth of around 18 metres.

b. Piling is expected to continue until September, after which the foundation system will be connected to the piles.

c. There are around 40 workers on site at the moment.

13) The people of Dunedin and the wider Southern region will be getting a state-of-the-art, fit-for-purpose facility with a significant increase in service capacity for the region. There will be 410 beds (compared to 367 current beds in the current hospital), 26 operating theatres (compared to 17), and three MRIs.

14) There will be several procedure rooms able to carry out minor surgery. There will also be larger day surgery theatres which means we can have more complex day surgery cases. The design also incorporates a surgical short-stay unit with 20 beds.

15) On 20 June you will meet with the Chief Infrastructure & Investment Officer, the Head of Infrastructure Delivery, GDO Hamish Brown, key NDH project leads and clinical staff who will be available to discuss and update you on the project. This will be followed by a tour of the NDH site which media will also attend.

16) We understand you are considering an announcement about the additional funding while on site [Draft Media Release at Appendix 4].

Discussion

17) Health NZ Southern provides healthcare services to a population of approximately 352,000 people across the region. The population is aging and expected to grow. Dunedin Hospital is the largest hospital in the Southern region and is a tertiary (teaching) hospital.

18) An indicative business case for the project for NDH was approved by Cabinet in 2017. In 2022, faced with a significant increase in the cost estimate, Ministers asked for options to be presented based on the initial design specifications for NDH.

19) Local clinicians were involved in the creation of design modification options as part of the value management exercise carried out in 2022 which resulted in savings of $90 million. Their focus was on ensuring service needs would be met in the new hospital. In some instances, this has meant building rooms but not completing the fit out, known as shelling (12/24 older persons mental health beds, one PET scanner and three theatres). This

retains the option of having the facilities in the future when they are needed.

20) It was felt that these changes would not impact on the delivery of health services and, as further design work has been undertaken, clinicians have provided further advice to eliminate residual clinical risk.

21) Following the announcement in December 2022 of $110 million to address cost escalations, a joint campaign by Dunedin City Council and the Otago Daily Times called for the original design to be reinstated along with the $90 million.

22) At this time, communications with local government, public and others had stalled since the value management exercise was carried out and stakeholders felt uninformed. There was also discontent with the new design. A campaign by the local Dunedin Council and Otago Daily Times against the stages was highly publicised. In an effort to build trust again in the project, communications and engagement have significantly improved with Project team representatives meeting with the council bi-monthly, regular updates to the community via forums and proactive media releases.

23) Updates on the project at the Local Advisory Group (LAG) meetings are provided on a bi-monthly basis. The LAG is made up of local and regional mayors, workforce groups, and other government agencies such as Waka Kotahi, and Health NZ representatives. The LAG has been chaired by former Dunedin North MP and Health Minister Pete Hodgson and he continues to have a presence.

24) A website has also been stood up to provide a single source of truth on the project, please see here New Dunedin Hospital.

Appendix 1: Runsheet for New Dunedin Hospital site visit on Thursday 20 June

Time	Details	Minister's Office notes
	Minister travels from the current Dunedin Hospital with GDO Southern Hamish Brown to NDH project office, 83 Castle Street, Dunedin Central	Drive into garage at project office.
11.00am	The Minister and his delegation will be met at the NDH Project Office. Greeted by Health NZ Chief Infrastructure & Investment Officer Jeremy Holman and IIG Head of Infrastructure Delivery, Blake Lepper. Introductions	
11.05am	Boardroom – Morning tea served	
11.10am	Brief overview about the project by: Infrastructure Programme Director Tony Lloyd and Southern Programme Director Bridget Dickson. Round-table discussion with infrastructure leads and clinical representatives	
11.30am	Health & Safety Briefing Put on safety gear before going to the site	
11.35am	Arrive on site (across the road) • Outpatient building site – Minister and officials to enter site, walk through some spaces, get a perspective of where MRI will be and other services. Inpatient building site – see piling underway from OB.	Media to meet in Southbase carpark – sign-in but not going onto the actual site. Photos of Minister entering site.
11.55am	Media standup in Southbase meeting room (next to Outpatients Building) Media Q&A.	
12.15pm	Other media depart. Minister to have one-on-one interview with Fiona Ellis, ODT	
12.30pm	Leave the site, back to NDH project office. Remove safety gear.	
1-1.30pm	Minister to meet with Deputy Mayor of Dunedin	Meeting room in NDH Project Office will be available

1.30pm	Minister departs for Te Kaika visit	

Appendix 2: Biographies of lead attendees

Jeremy Holman, Chief Infrastructure & Investment Officer, Health NZ

As a former Royal Engineer officer in the British Army, Jeremy led a number of specialist units delivering critical infrastructure and large-scale construction programmes both on operational deployments and in the UK defence estate. He was awarded an MBE for this work in 2007.

He moved to New Zealand with his family in 2009 and was employed by the infrastructure consultancy GHD before moving to Downer as the General Manager Water. He also spent time at Air New Zealand as a member of the Senior Leadership Team responsible for ground handling operations in New Zealand and around the world. Before joining Health NZ, Jeremy was GM Infrastructure Delivery for Crown Infrastructure Partners, delivering a number of major infrastructure programmes receiving $6 billion of NZ Government stimulus funding.

Jeremy holds two engineering degrees, a Master of Business Administration, and is a Chartered Engineer and a Fellow of the Institution of Mechanical Engineers (UK).

Blake Lepper, Head of Infrastructure Delivery, Health NZ

Blake joined Health NZ in February 2024, after almost five years with the New Zealand Infrastructure Commission (Commission) where he was General Manager of Infrastructure Delivery. In his time there, Blake was called on to give advice to Ministers on some of New Zealand's largest infrastructure projects and work with agencies to develop their delivery capability.

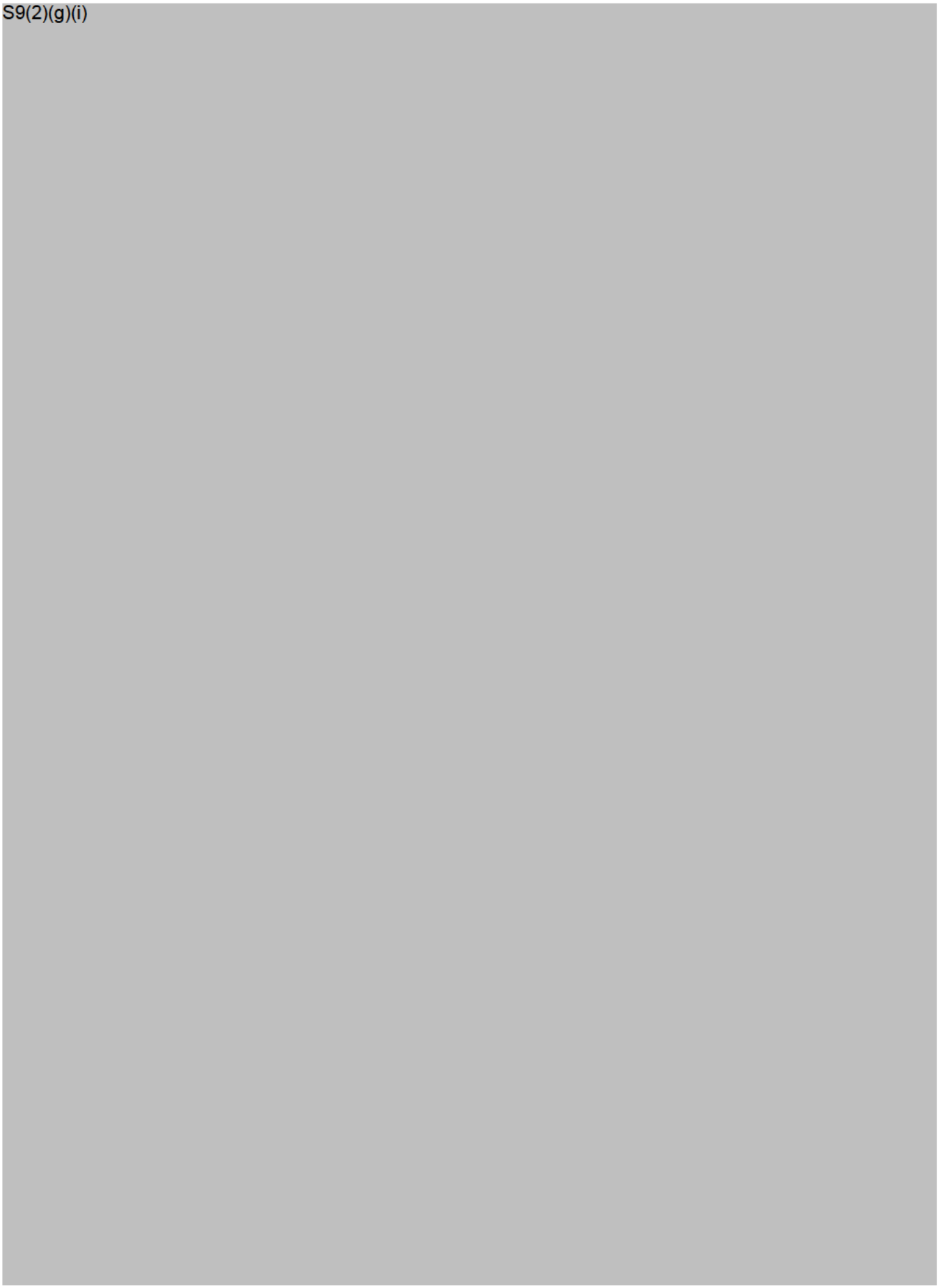
While at the Commission, he was involved in supporting the formation of the Health Infrastructure Unit in the Ministry of Health and Health NZ's Infrastructure & Investment Group (IIG). Blake worked closely on Dunedin, Whangārei and Nelson Hospitals, developing the Health Infrastructure Report, supporting the IIG operating model and reviewing the Mental Health Infrastructure Programme.

Prior to joining the Commission, Blake was heavily involved in the Canterbury earthquakes rebuild.

Hamish Brown, Group Director of Operations, Southern

Hamish joined the former Southern District Health Board, now Health NZ - Southern, in March 2019 as Programme Director for the New Dunedin Hospital. From March to November 2021 Hamish worked as the SRO (Senior Responsible Officer) for the COVID vaccination rollout programme, before moving into the Chief Operating Officer role and then Interim Lead for Hospital and Specialist Services. He previously worked as an Emergency Nurse, and in leadership roles in the West Coast and Canterbury District Health Boards. Hamish brings a wealth of knowledge of our health system, staff and community to the Group Director of Operations role. He brings extensive leadership experience, strategic thinking, empathy and relationship building skills that are essential for leading our Health NZ Southern team.

S9(2)(g)(i)



S9(2)(g)(i)

Appendix 4: Q&As / Reactives

Is the project on schedule?

Timelines are regularly evaluated and at this stage the project is on schedule to be fully operational in 2029.

What is the fit-out of 6-10 years recently mentioned referring to?

This refers to the fitting out of shelled spaces that will increase NDHs capacity as demand requires. It's about future-proofing the hospital for years to come.

When the hospital first opens, for example, we will have 23 operating theatres and procedure rooms operational, and 3 shelled. The 3 shelled theatres can be fit out in the following years as demand requires. Other spaces that will be warm-shelled so we can increase capacity in future include space for a PET-CT scanner and an additional 12 beds.

What is the current budget of NDH with this additional funding?

$1.59 billion. (Please note, Digital infrastructure is a separate budget).

What does Health NZ have underway in its infrastructure building programme other than NDH?

The Infrastructure & Investment Group has over 1,500 capital projects underway, at various stages of planning and delivery, across the country. These range from a few thousand to hundreds of millions of dollars' worth.

Can you be sure clinical risks identified during the re-design have now been addressed?

Further design and consultation with clinical leads was undertaken and the reinstatement of the MRI, fitting out of some shelled spaces and a review into Pathology have addressed those risks.

Will there be more cuts due to these latest cost pressures?

Preliminary design of the hospital has been completed and shared publicly. Further developed design has also been completed.

When delivering an infrastructure project of this scale, it is important that we monitor and manage costs to ensure there are no further disruptions down the track and we deliver a state-of-the-art hospital to the region.

Why won't a PET scanner be funded?

There are currently no PET scanners in public hospitals. A national plan for PET CT provision would identify whether the provision for one in NDH would provide more equitable health outcomes. To future proof that eventuality, the space designated for a PET scanner will be prepared as a 'warm' shell.

In addition, Pacific Radiology is currently building a facility in Dunedin, in close proximity to the hospital. Pacific Radiology - New PET-CT scanner for Dunedin arriving in 2025

What does shell space mean?

Cold shell is simply a shell of the building without any services (electrical, water, sewer for example). Services will generally run to the perimeter of the space so that there is capacity in the system to accept the additional loads.

Warm Shell Space will include services in the actual space and may include some wall linings, and so on, but is not fully fitted out.

Why can't we fund scanners and theatres rather than just preparing shell spaces?

This is about preparing for capacity demands. Building and fitting out a shell space for a PET CT scanner means the NDH will have the space needed for this equipment should/when demand for these services are needed.

Capital fund planning of when to fit out theatres that are shelled, will be an important part of how Health NZ plans and manages its investment infrastructure across the motu as demand pressures increase.

How was the build delayed because of the value management process that was carried out (in 2022)?

Delays of up to 10 months have already occurred due to the value management exercise. Further design changes - or reverting to the previous design - are likely to delay construction and the completion date of the facility even further at this stage.

Which clinicians contributed to the design of the NDH?

The design and user consultation for the New Dunedin Hospital has been underway for several years and a very large number of clinical and non-clinical users have been engaged at some point. Around 500 people have been involved in the consultation process since 2017, across approximately 50 groups.

The clinical advisory group now called the Clinical Transformation Group (previously called the Clinical Leadership Group) has been involved in the New Dunedin Hospital project development since the outset. This group has maintained interprofessional representation and consumer membership, and during a refresh of the membership in early 2022, a nomination process for iwi membership is underway.

Has the pathology business case been started?

Work has commenced on a business case for the pathology building.

Are there any additional costs not included in the NDH business case? If so, how will they be funded?

Carparking, decommissioning of the current hospital and the Pathology building is expected to be $300 - $400 million. Funding options are yet to be confirmed.

Note this does not include the cost of digital infrastructure which has a separate business case and funding.

Why are costs for projects escalating or changing from what has been announced?

All infrastructure projects are currently facing major cost increases as a result of supply-chain issues and global inflation pressures. The Health NZ Infrastructure & Investment Group are taking the appropriate steps to mitigate the risk of cost escalation.

Government infrastructure projects do not get an exemption from the construction cost pressures being felt here in New Zealand. There are associated supply chain disruptions, higher product and shipping costs and a shortage of skilled labour, all increasing the price of construction.

Data & Digital/tech Q&As

What is the information technology component?

The information technology component is $82 million for Stage one of the digital transformation project.

In April 2023, Ministers approved $82 million of funding to be released for Stage 1 of the digital programme ($14 million funded by Health NZ and $68 million from the Crown). The funding will cover the digital infrastructure work that is required for the Outpatient building, work on existing digital solutions to make them work effectively with the new Outpatient building and there is also funding for the future business case work needed for the inpatient building.

PLEASE NOTE: This was a separate business case, not part of the NDH Business Case.

W**hat digital infrastructure will be in place when the outpatient building opens in 2026?**

All digital infrastructure required for the operation of a contemporary facility will be in place when the outpatient building opens. The more obvious signs of this will be digital wayfinding services, check in kiosks and information displays but behind the scenes network, cellular coverage, WIFI, connectivity and building management functions will also be in place together with computing requirements of the building and the connection of the medical devices that will be used in the new facility.

What will the impact of this funding release be for patients and staff using the new building and the health sector in general?

The impact for patients is that they will be able to navigate to their appointments more seamlessly and, after checking in digitally, they will receive updates about when their appointment will occur. They will be able to wait for notifications in the café rather than the waiting room.

The implementation of paper-lite initiatives (including scanning) means that clinicians will be able to access the information they need from the electronic clinical portal rather than a paper medical chart, enabling them to access information immediately and allowing multiple clinicians to access the same information at once.

The health sector in general will benefit from the initial investment that has been made in the design of the digital infrastructure as we anticipate that at least 50% of the completed digital infrastructure design can be reused by other hospital builds and this information is already starting to be shared for this purpose.

Appendix 5: 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 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 $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
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

Date	Decision	Budget
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 by Health NZ, Te Pūkenga and the University of Otago.	Estimated costs for the ILC exceeded $140 million, making each party's share >$50 million. The amount budgeted for the ILC in the NDH project budget was $17 million.
May 2023 [HNZ00029011]	The pathology review recommended that anew 4000m^2 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 fit out). This is not currently funded, so the pathology provision will stay in the old hospital until funding is available.
March 2024 [CAB-24-MIN-0095]	Release of $290 million from the DHB Equity Support Capital Contingency has been agreed by Cabinet, subject to approval of an Implementation Business Case. Funding required due to cost pressures s9(2)(b)(ii), 9(2)(j)	Total: $1.88 billion

Briefing

Health New Zealand
Te Whatu Ora

New Dunedin Hospital Update for Meeting with Infrastructure Ministers on 18 June 2024

Due to MO:	17 June 2024	**Reference**	**HNZ00052372**
To:	Hon Dr Shane Reti, Minister of Health		
From:	Jeremy Holman, Chief Infrastructure and Investment Officer		
Copy to:	n/a		
Security level:	In Confidence	**Priority**	Routine
Consulted	n/a		

Action sought	**Action required by**
Agree to provide a copy of this briefing to the Minister of Finance, Minister for Infrastructure and the Minister for Regional Development with to inform their meeting on 18 June.	17 June 2024

Contact for further discussion (if required)

Name	**Position**	**Phone**	**1st contact**
Blake Lepper	Head of Infrastructure Delivery	s9(2)(a)	x
Jeremy Holman	Chief Infrastructure and Investment Officer	s9(2)(a)	

Attachments	
Appendix 1:	**NZ Infrastructure Commission summary of NDH Independent Review**

Purpose

1) This briefing outlines Health New Zealand's | Te Whatu Ora's plans to implement the New Dunedin Hospital Independent Expert Review (Independent Review) recommendations. We recommend you provide a copy to the Minister of Finance, Minister for Infrastructure and the Minister for Regional Development (Infrastructure and Investment Ministers) before their meeting on 18 June 2024.

Summary

2) Health NZ has been assessing how to implement the New Dunedin Hospital Independent Expert Review findings and is taking steps to implement the 14 recommendations.

3) s9(2)(b)(ii), 9(2)(j) Health NZ now expects to submit the Interim Implementation Business Case for Joint Ministers' approval following the receipt of Target Outturn Cost 2 for the Inpatient Building, scheduled for 31 July.

4) Health NZ is establishing an Oversight Group to implement these and all other recommendations.

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

Recommendations

Health New Zealand | Te Whatu Ora recommends that you:

a)	**Note** that Health NZ has been assessing how to implement the Independent Expert Review findings and is taking steps to implement the 14 recommendations.	**Noted**
b)	**Note** s9(2)(b)(ii), 9(2)(j)	**Noted**
c)	**Agree** to provide a copy of this briefing to the Minister of Finance, Minister for Infrastructure and the Minister for Regional Development to inform their meeting on 18 June.	**Yes/No**

s9(2)(a)

Hon Dr Shane Reti,
Minister of Health

Date:

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

Date:

Background

6) On 30 May 2024, the Infrastructure Commission provided you and the Infrastructure and Investment Ministers the final report resulting from the independent expert review of the New Dunedin Hospital (NDH) project. They also provided a summary of the 14 recommendations from the Independent Review (attached as Appendix 1).

7) The Health NZ Capital and Infrastructure Committee has received and discussed the Independent Review findings. The Health NZ Board will be briefed at their meeting next week.

8) Health NZ has been assessing how the recommendations can be implemented and the optimal timeframe and sequencing, given the current status of the NDH project which is at a critical juncture.

Overview of findings from the Independent Review

9) We have summarised the findings from the Independent Review below. Our summary is not substantively different from the Infrastructure Commission's though we have added some context and detail.

Budget and Cost Certainty

10) **Insufficient budget**: The approved budget for NDH is likely to be insufficient to cover the current project scope. This insufficiency is exacerbated by ongoing cost escalations in materials and skilled labour, as well as the impacts of COVID-19 on the construction industry.

11) **Critical cost deliverables**: To achieve greater cost certainty, three key deliverables are required: a developed design estimate from Health NZ's Quantity Surveyor; the Target Outturn Cost 2 tender submission from the Contractor; and a robust Quantitative Risk Assessment. These deliverables are expected to provide a more accurate and reliable cost estimate, aligning the budget with current market conditions.

Governance Structure

12) **Role clarity and independence**: The current governance structure requires adjustment to effectively deliver the benefits outlined in the Final Detailed Business Case. Specifically, there is a need to separate the roles of the Senior Responsible Owner (SRO) and the Project Steering Group Chair (Chair), ensuring the Chair is genuinely independent. This separation is crucial for enhanced oversight and effective decision-making.

13) **Focus on operational readiness**: The governance structure should place a greater emphasis on operational readiness as the project moves into its next phase. This includes ensuring that all required capabilities are in place to support hospital operations and service delivery.

Scope Definition and Management

14) **Fluid scope:** The current project scope includes unresolved issues and potential changes, leading to scope fluidity that complicates obtaining necessary signoffs as designs are finalised. This fluidity poses a risk to project stability and progress, making it essential to urgently fix the scope and avoid further changes unless they are absolutely necessary to ensure the facilities remain fit-for-purpose.

Operational Readiness and Resourcing

15) **Transition and resourcing plan**: The Independent Review underscored the importance of having a clear resourcing plan to manage the project effectively under the new parameters. This plan should outline staffing requirements, roles and responsibilities, ensuring that adequate resources are in place for successful project and programme management and operational readiness.

16) **Impact on services**: There is a critical need to develop a comprehensive business case that confirms how residual services not provided within the new facility will be delivered, detailing the investment costs associated with these services. This is essential to ensure seamless service delivery across the Dunedin City Health Campus.

Contract Execution Timing

17) **Risk of premature contract signing**: The Independent Review recommended delaying the execution of the construction contract for the Inpatient Building to avoid the risks associated with signing the contract before obtaining stronger cost certainty. Executing the contract prior to receiving the necessary cost deliverables could lead to significant reputation damage and potential time and cost impacts if the contract needs to be terminated due to an uneconomic submission.

Discussion

18) Health NZ's high-level response to the Independent Review is as follows:

a) Many of the Review's findings relate to legacy/carryover issues resulting from the complex history of the NDH project and the major global events and organisational changes that have occurred over its lifespan. Health NZ welcomes the Independent Review as it has brought these issues more clearly to the fore and has highlighted the need for further improvement.

b) Though focused on NDH, many of the Independent Review recommendations relate to Health NZ's programme/project governance and management structure generally. Therefore, there is an opportunity to implement the recommendations across all Health NZ major programmes/ projects.

c) This will require a degree of organisational change and therefore careful planning and change management – but the urgent priority is to give Ministers confidence that NDH is fit-for-purpose and affordable so that a decision can be made on executing a construction contract with CPB for the Inpatient Building.

Next Steps

19) Health NZ is taking the following next steps to implement the Review findings.

Delay Contract Execution to Enable Great Cost Clarity; Interim Project Measures

20) Health NZ has informed CPB of a necessary delay to execution of the construction contract for the Inpatient Building. This will allow time to incorporate key cost-related elements into the Interim Implementation Business Case:

a) **A developed design estimate**, and

b) **CPB's own assessment of the quantum of Target Outturn Cost 2** in order to begin negotiation with Health NZ over this sum – expected to be completed by December 2024.

21) Health NZ now expects to complete the Interim Implementation Business Case in the period following receipt of Target Outturn Cost 2, currently scheduled for 31 July 2024.

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

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

Establish an Oversight Group

26) An oversight group will be formed within Health NZ to govern the implementation of the Independent Review recommendations. The oversight group will initially focus on developing and overseeing execution of an inplementation plan for the time-sensitive NDH actions.

27) The oversight group will include at a minimum the Health NZ Head of Infrastructure Delivery, Regional Head of Infrastructure, Regional Director Hospital and Specialist Services, Head of Investment and Planning and Regional Director Data & Digital. We are finalising the group's members to ensure it can provide comprehensive oversight and effective decision-making.

28) The oversight group will be supported by an independent Chair, as recommended in the review. An appointment process is underway.

Develop a Resourcing Plan

29) Health NZ will develop a detailed resourcing plan to manage NDH effectively under the new parameters. The resourcing plan will outline staffing requirements, roles and responsibilities, and training needs to ensure that the project is adequately resourced. It will also identify any gaps in current resourcing and propose solutions to address these.

30) A well-defined resourcing plan will support efficient project management, enhance operational readiness, and ensure that all capabilities required for successful hospital operations are in place.

Develop a Business Case for Residual Health Services

31) Separate to the Interim Implementation Business Case for the Inpatient Building, Health NZ will develop a Detailed Business Case to propose how residual Dunedin health services can be delivered and their cost. This will address any gaps in service provision and ensure seamless service delivery across the Dunedin City Health Campus.

Improve Governance and Reporting

32) Health NZ will implement the recommended governance structure changes, including separating the roles of the SRO and the Project Steering Group Chair, and appointing an independent chair.

33) Health NZ will improve the quality and frequency of project reporting to provide greater transparency and assurance to the government and stakeholders about the project's status. This includes detailed updates on scope, milestones, budget and risks.

Financial implications

34) 9(2)(b)(ii) [redacted]

Event Briefing

Health New Zealand
Te Whatu Ora

Visit to Dunedin Hospital, Thursday 20 June 2024

Due to MO:	19 June 2024	**Reference**	**HNZ00052563**
To:	Hon Dr Shane Reti, Minister of Health		
From:	Hamish Brown, Group Director of Operations, Southern		
Copy to:	n/a		
Security level:	**In Confidence**	**Priority**	Urgent
Consulted	n/a		

Contact for phone discussion (if required)

Name	Position	Telephone	1st contact
Hamish Brown	Group Director of Operations, Southern	S9(2)(a)	x
Kate Mackersy	Communications Team Leader, Southern and South Canterbury		

Attachments

Appendix 1:	Runsheet

About the event

Purpose	The purpose of this visit is for you to be welcomed to the Dunedin Hospital site, meet with the local leadership and clinical team, and tour the Hospital. Later that day you are also visiting the New Dunedin Hospital site (11am – 12:30pm) and Te Kāika Wellbeing Hub (2 - 3pm). Hamish Brown will be accompanying you on all three visits.
Date	Thursday 20 June 2024
Time	9am – 10.55am
Venue	Dunedin Hospital, 201 Great King Street, Central Dunedin
Health New Zealand | Te Whatu Ora representatives	• Hamish Brown, Group Director of Operations, Southern • Bridget Dickson, New Dunedin Hospital Programme Director • Dr Hywel Lloyd, Director Quality & Clinical Governance, Southern • Craig Ashton, General Manager • Jenny Hanson, Director of Nursing • Tracy Hogarty – Director of Allied Health • Mr Philip Davis, Medical Director: Surgical Services and Radiology • Dr Rebecca Brushwood, Medical Director: Women's and Children's • Dr Clarie Ireland, Anaesthetist • Melissa Law, Service Manager: Surgical Services & Radiology • Alison Aumata, Service Manager: Southern Blood and Cancer Service • Dr Louise Bremer, Medical Oncologist • Therese Duncan, Associate Director of Nursing • Nancy Todd – Senior Localities Manager, Commissioning
Media	No media are expected at the Dunedin Hospital visit.

Background

1. The purpose of this visit is for you to be welcomed to the Dunedin Hospital site, meet with the local leadership and clinical team, and tour the Hospital.
2. As this is your first visit to Dunedin Hospital as Minister of Health, the local Runanga and Manuwhenua will welcome you on site with a formal Mihi Whakatau.
3. You will then be meeting with some of our local leadership and clinical teams, followed by a tour of the Operating Theatres, Sterile Services, and Southern Blood and Cancer services.

Dunedin Hospital

4. Dunedin Hospital is a tertiary hospital located in central Dunedin. It services around 350,000 Southern residents across Otago and Southland – a geographical region of 62,400 km^2.

5. Dunedin Hospital includes:

    - 24/7 Emergency Department
    - Intensive Care Unit (ICU) with a regional helicopter retrieval service
    - Neonatal Intensive Care Unit
    - Coronary Care Unit
    - Medical and Surgical Wards and tertiary level services
    - Children's Ward
    - Assessment, Treatment and Rehabilitation Ward
    - Medical Assessment Unit
    - Radiology including MRI (two), CT, Ultrasound, Nuclear Medicine, and Intervention Radiology
    - Outpatients Clinics
    - Maternity and Primary Birthing Care
    - Emergency Psychiatric Services

6. On average, there are 140 presentations to the Emergency Department each day.

7. Dunedin Hospital receives transfers and retrievals from across all of the Southern district. Some are primary helicopter retrievals which go directly to ED or ICU, some are repatriated patients coming back to Dunedin, and some are direct transfers from Lakes District Hospital and Southland Hospitals.

8. ICU has a dedicated retrieval team and works closely with Otago Regional Rescue Helicopter to fly patients to Dunedin Hospital.

9. Dunedin Hospital now runs a fixed-wing air ambulance service. For the period June 2023 – May 2024 there were 97 fixed-wing transfers from Dunedin Hospital to other locations.

Workforce

10. Around 3,500 staff work at Dunedin Hospital:

    - Nursing: 1,831
    - Allied Health, Technical and Scientific: 540
    - Management and Administration and Support: 611
    - Resident Medical Doctors: 275
    - Senior Medical Officers: 244

11. In 2024, 54 new graduate nurses and midwives, and 71 Resident Medical Officers will begin their careers at Dunedin Hospital

Operating Theatres

12. Dunedin Hospital has nine main operating theatres, a dedicated maternity theatre and three Day Surgery theatres (including Filleul Street Surgical Centre (ophthalmology).

13. Either two or three acute theatres are scheduled Monday to Friday. There is an acute theatre on Sunday and – since April 2024 – on three out of every four Saturdays, two acute theatres are operating. On average, 180 acute operations are performed each month.

14. Acute life and limb care is available 24/7.

15. Elective operations are performed Monday to Friday. On average, 480 elective operations are performed each month.

16. On average, 14 cases per week (59 per month) are cancelled on the day of surgery. The main reasons for elective surgery cancellations on the day of surgery are:

    - Acute patients taking priority
    - Ward block and no bed for patient
    - Not enough list time as previous cases have taken longer than expected.

17. There are ongoing issues with the theatres, primarily due to the age of these spaces. Issues include limited storage, inefficient space for equipment and HVAC system concerns.

Sterile Services

<u>Service</u>

18. Sterile Service Units process or reprocess reusable medical devices. Within these units, medical devices undergo specialist cleaning, disinfection or sterilisation and – where applicable – safe storage to minimise the contamination of medical devices that might contribute to post-surgical infections.

19. Dunedin Hospital Sterile Services have two separate units within the end-of-life Clinical Services Building (CSB).

20. Central Sterile Supply Department (CSSD) services the two Day Surgery theatres, the Filleul Street Surgical Centre, and all general and specialty outpatient clinics and inpatient wards.

21. The Theatre Sterile Supply Unit (TSSU) services nine operating theatres on the 5th floor and the obstetric theatre on the 2nd floor of Ward Block.

22. Neither unit meet current standards and they produce a higher number of contaminated instruments than comparable units. This has a significant impact on patients, theatre staff and theatre efficiency.

23. $14m has been allocated in this year's capex for a redevelopment project to replace both CSSD and TSSU. A business case is in the final stages of completion to go the Capital

Investment Committee. Completion of this project is a dependency of the NDH outpatients building (opening 2026) as the current units do not have the capacity to meet the demand of the additional theatres.

24. A second business case is with the regional Data and Digital team for an instrument tracking system. Southern does not currently have a digital tracking system, which is required under the national compliance standard AS/NZ 4187:2014. Dunedin is the only tertiary hospital in New Zealand not to comply. This is also a key efficiency requirement for when outpatients building goes live as instruments will be moved and used across multiple sites.

Southern Blood and Cancer Services

25. The Southern Blood and Cancer Service (SBCS) is located at Dunedin Hospital and provides a district-wide cancer service to the southern half of Te Waipounamu (south of Canterbury). This includes haematology, radiation, and chemotherapy treatment.

26. While we continue to experience workforce challenges, we remain committed to providing timely cancer services in Dunedin long-term.

27. No cancer services have stopped, and all patients continue to receive the treatment they need. This may include being managed remotely by a Dunedin-based doctor for patients living in a rural location or remotely by a doctor based at a hospital elsewhere. Some patients are receiving treatment outside the Southern district. This is discussed individually with patients and their whānau and is an option for people with certain non-complex conditions.

28. Southern is outsourcing some telehealth Radiation First Specialist Appointments. This means that a patient can speak to the radiation oncologist via telehealth in a virtual meeting. That doctor will also complete the treatment plan, liaise with treating staff, and follow up with the patient to ensure continuity of care. The patient's treatment is delivered locally at Dunedin Hospital by Medical Physicists, Radiation Therapists and Nursing staff. There are always on-site Registrars overseen by Radiation Oncologists.

29. For some patients who require less complex care and treatment, the option to be treated outside the Southern district is discussed with the patient and their whānau. This is to help manage the current local capacity constraints and to ensure patients have access to timely treatment.

30. Although we see as many patients as possible within appropriate timeframes, we continue to face significant challenges due to the demand for our services and resource constraints. Unfortunately, this impacts many of our patients, resulting in extended waiting times.

31. SBCS First Specialist Appointments (FSAs) delivered:

	1 Jan 22- 31 Dec 22	**1 Jan 23 – 31 Dec 23**
Radiation Oncology	855	1,024
Medical Oncology	402	546
Haematology Oncology	354	373

32. In 2023, SBCS delivered 8,086 chemotherapy treatments across Southern (Dunedin and Southland Hospital, and rural Hospitals), and 1,108 radiation treatment courses at Dunedin Hospital.

Health and Disability Commissioner (HDC) Report April 2023

33. Health NZ Southern accepted the Health and Disability Commissioner's decision in relation to the delivery of Southern's non-surgical cancer service, including delays in patients obtaining FSAs over the period 2016 to 2022.

34. Southern has implemented the Report's immediate recommendations and we are continuing to work on the longer-term recommendations. Southern provided the required three-month update to the HDC on 13 July 2023.

35. Health NZ accepted the Health and Disability Commissioners Addendum to 12 April 2023.

36. We acknowledge and appreciate the ongoing interest and concerns about Southern Blood and Cancer Services at Dunedin Hospital. We remain committed to providing timely and accessible cancer services to the Southern community.

Royal Australia and New Zealand College of Radiologists (RANZCR) Accreditation

37. Dunedin Hospital received correspondence from the RANZCR on 29 August 2023 notifying the withdrawal of accreditation for Radiation Oncology Training, effective 2 October 2023.

38. RANZCR acknowledged the detailed action plan provided by Southern, however it also noted the ongoing Radiation Oncologist staffing challenges which would affect the ability to effectively train and supervise Trainees under RANZCR requirements.

39. Southern accepted the decision to withdraw accreditation and is working to reapply for accreditation in 2025.

Patient communication

40. All patients referred to the Southern Blood and Cancer Service receive a letter outlining their referral and process going forward. This letter has been updated following the HDC recommendations and in consultation with the Southern Community Health Council. The updated letter has been used since 14 July 2023. It informs patients that Southern has received their referral, the expected wait time, and apologises for any delay in providing an appointment. The letter includes a direct contact number for the Patient Navigator Team and explains the support this team offers, including information for accessing clinical, psychological, and social support. It also provides information on what to do if the patient's symptoms change.

41. Our Patient Navigators are a team of specialist registered nurses who can check in on patients and provide advice and updates on wait times. They can also signpost patients to other support services such as their GP, our Cancer Psychosocial Team, and the Cancer Society

Workforce

42. Workforce capacity is a critical part of the overall planning process for the provision of cancer services across Aotearoa.

43. Southern is currently fully recruited to budget for both Medical Oncology and Haematology Senior Medical Officers (SMOs).

44. Southern continues to actively recruit to meet future demand, created by the availability of new treatments and the aging population.

45. Southern has three permanent Radiation Oncologists (ROs). We also have a range of locum ROs providing support while we continue to recruit up to a further four permanent ROs. This support has been a mix of short-term international locums and regular on-site visits and telehealth consults, including the provision of remote treatment planning. We have a new permanent SMO starting in July and another starting in August. A further international candidate is also under offer to start at the beginning of 2025.

46. Southern acknowledges that all three oncology specialties (haematology, radiation and chemotherapy) continue to be vulnerable to increasing demand and workforce pressures.

47. Radiation oncology requires a multidisciplinary team comprising of senior medical officers, resident medical officers, radiation therapists, medical physicists, nurses, health care assistants, administrative personnel, social workers, psychologists, dietitians, and other allied health professionals.

48. The Health NZ updated Workforce Plan, which is due to be in place in mid-2024, will include a focus on cancer care workforce needs, and will ensure we have a pipeline for all specialist cancer workforces, including radiation oncology.

49. The National Radiology Group, established in 2023, and has been instrumental in assisting with additional radiation oncology trainees, standardising some pathways, and supporting the movement of patients to reduce treatment waiting times.

Risks and Issues

Dermatology Outpatient Appointments

50. Like many specialty services across the health system, dermatology is experiencing staffing challenges.

51. Dermatologists are a very small and specialised medical workforce and account for around 30 people nationally (at around 22 FTEs) in the public health system.

52. The South Island has had long standing vacancies within the dermatology workforce, and the locum dermatologists who were covering Dunedin and Southland Hospitals have stepped back from providing this cover. We are actively seeking locum cover for these vacancies and continue to recruit permanent dermatologists.

53. While recruitment is underway, Southern is not able to accept any dermatology outpatient referrals or offer dermatology outpatient appointments. We know that this news will be distressing to those patients who are affected.

54. We have notified our primary care colleagues and encourage patients to see their family doctor while we recruit.

55. Patients who receive medication in hospital for their dermatological condition will continue to receive their treatment.

56. GPs can still make dermatology referrals for suspected skin cancers, as they usually would, as these are dealt with by our General Surgery, Plastics and ENT departments, depending on the referral process.

57. We are working with our WellSouth colleagues to provide continued support for patients who receive their treatments in the community.

South Island Patient Information Care System (SI PICS)

58. SI PICS was rolled out across Southern in November 2023.

59. There have been multiple performance issues with the transition from Integrated Patient Management Systems (IPM) to SI PICS.

60. This is partly due to older infrastructure which has complicated the transition. We are in the process of updating this infrastructure to further improve the service. Challenges arising from data migration have also been a factor. Changing IT systems involves migrating data from the old to the new environment and has not gone as smoothly as planned. There are known issues which are being addressed by our IT support team with fixes applied along with appropriate data validation. The team are working hard to resolve issues as quickly as possible.

61. This month we are on track to upgrade some of the underlying infrastructure that will improve overall performance for users. The has meant installing new equipment, such as central processing units, to enhance the speed of the administration system. We are engaged with all staff using the system to ensure we can respond to needs and review and system performance as required. This is an ongoing process, along with providing training and support to our staff on the new system.

62. Having Southern on the same centralised patient administration system that is already in use in Nelson, Marlborough, Canterbury and South Canterbury enables us to better effectively manage patient appointments, waiting lists, admissions, discharge and transfers, creating a better patient experience.

Oamaru Hospital

63. Health NZ will assume operational control of the Ōamaru Hospital from 1 July 2024.

64. This transition is supported by the sale and purchase agreement between Waitaki District Health Services Ltd (WDHSL) and Health NZ that has been approved by Waitaki District Council. The agreement includes the purchase WDHSL's clinical equipment, stock, and taking over licenses, equipment operating leases and service agreements.

65. The agreement underpins a seamless transition from 1 July for staff and those using services. All staff currently employed by WDHSL have agreed to transfer to Health NZ, and we look forward to welcoming staff to Health NZ on 1 July.

ESPI 2 and 5 Performance

Medical Specialties - ESPI-2 - Long Wait > 4 Months

Dunedin Hosptial - All Ethnicities

	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24
M96 - Diabetology	1	4	4	4	5	9	10	13
M95 - Endocrinology	7	7	40	75	75	77	65	51
M70 - Rheumatology	8	11	14	18	22	23	21	47
M65 - Respiratory Medicine	57	50	74	120	120	157	135	132
M60 - Renal Medicine	6	5	5	5	9	14	14	17
M55 - Paediatric Medicine	12	8	2	5	6	21	25	16
M50C - Radiation Oncology	0	0	4	1	0	2	0	0
M50 - Oncology	3	2	1					
M45 - Neurology	138	191	265	270	269	254	225	202
M30 - Haematology	4	8	10	11	21	18	15	7
M25 - Gastroenterology	5	9	9	15	21	32	32	41
M15 - Dermatology	208	189	199	207	228	241	216	185
M10 - Cardiology	9	10	26	42	55	89	69	67
M00 - General Medicine	3	2	3	8	11	25	10	7
	461	**496**	**656**	**781**	**842**	**962**	**837**	**785**

Surgical Specialties - ESPI-2 - Long Wait > 4 Months

Dunedin Hosptial - All Ethnicities

	23-10	23-11	23-12	24-01	24-02	24-03	24-04	24-05
S75 - Vascular Surgery	88	82	85	85	80	85	88	86
S70 - Urology	90	104	130	161	188	203	218	205
S60 - Plastic Surgery [excluding burns]	114	106	110	128	146	156	176	173
S59 - Specialist Paediatric Surgery [Others]	4	2	2	5	4	3	8	8
S45 - Orthopaedic Surgery	379	404	445	498	506	548	517	468
S40 - Ophthalmology	95	115	147	106	75	67	65	83
S35 - Neurosurgery	32	32	34	37	15	11	10	7
S30 - Gynaecology	73	85	82	116	112	109	130	131
S25 - Otorhinolaryngology (ENT)	262	272	372	423	431	477	498	478
S15 - Cardiothoracic Surgery	0	0	0	0	0	3	2	2
S05B - Pain Management	8	14	26	30	32	30	27	30
S00 - General Surgery	238	232	261	301	317	314	346	379
	1383	**1448**	**1694**	**1890**	**1906**	**2006**	**2085**	**2050**

All Specialties - ESPI-5 - Long Wait > 4 Months

Dunedin Hosptial - All Ethnicities

	23-10	23-11	23-12	24-01	24-02	24-03	24-04	24-05
M10 - Cardiology	2	2	2	3	3	2	1	1
S00 - General Surgery	39	38	45	73	72	82	77	74
S15 - Cardiothoracic Surgery	6	3	2	3	3	4	4	4
S20 - Dental Surgery	1	2	1	1	2	3	3	2
S24 - Maxillo-Facial Surgery	6	6	7	8	8	7	7	5
S25 - Otorhinolaryngology (ENT)	224	193	204	254	274	315	299	288
S30 - Gynaecology	109	108	135	153	158	184	195	187
S35 - Neurosurgery	16	14	9	10	8	7	7	2
S40 - Ophthalmology	112	145	161	215	241	272	262	258
S45 - Orthopaedic Surgery	645	624	693	720	716	726	701	650
S59 - Specialist Paediatric Surgery [Others]	3	0	2	5	7	8	10	9
S60 - Plastic Surgery [excluding burns]	104	98	108	109	111	104	90	81
S70 - Urology	61	67	71	132	129	132	129	113
S75 - Vascular Surgery	31	30	31	36	35	37	37	39
	1359	**1330**	**1471**	**1722**	**1767**	**1883**	**1822**	**1713**

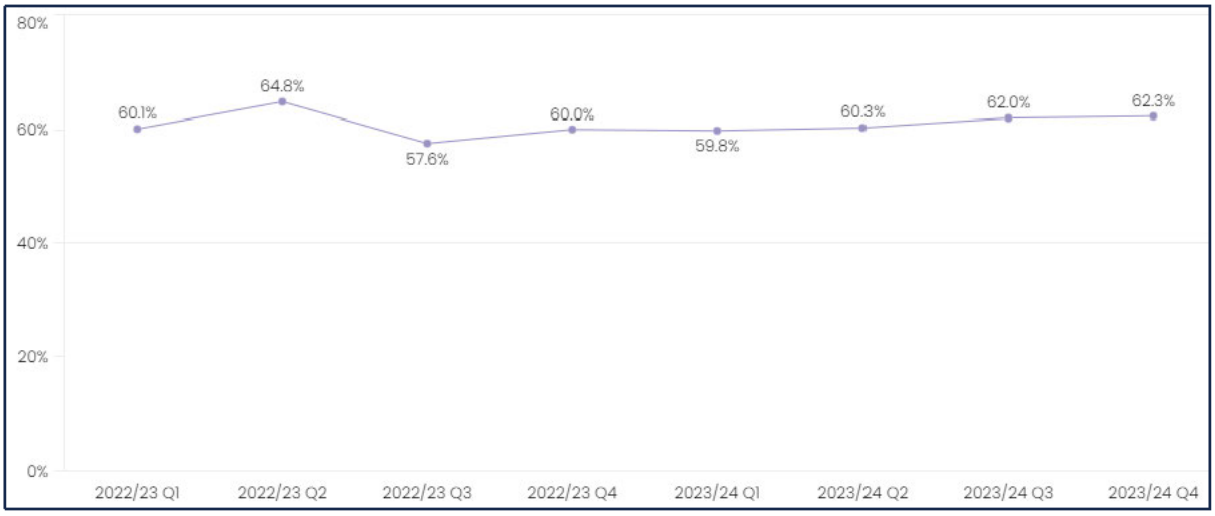
All Specialties - ESPI-5 - Long Wait > 1 Year

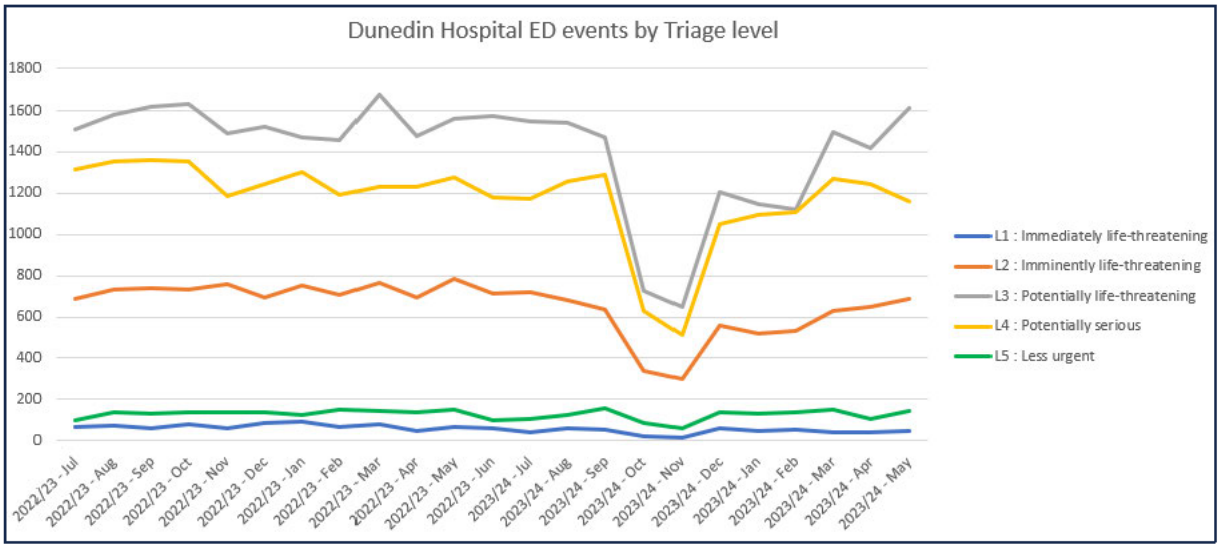
Dunedin Hospital - All Ethnicities

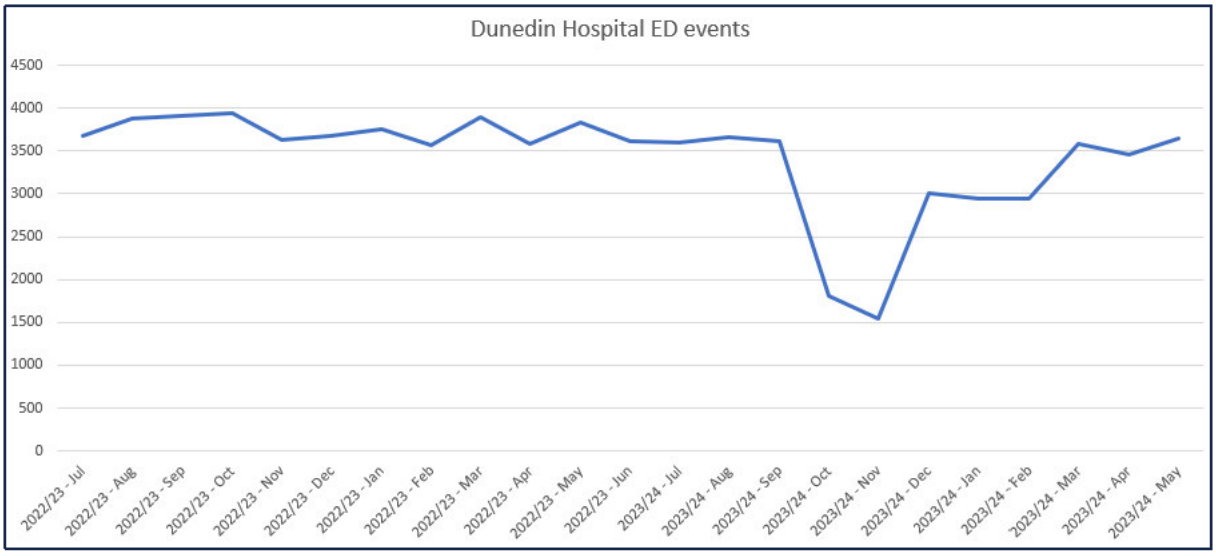
	23-10	23-11	23-12	24-01	24-02	24-03	24-04	24-05
M10 - Cardiology	0	0	0	0	0	1	1	1
S00 - General Surgery	12	8	8	8	9	11	8	6
S15 - Cardiothoracic Surgery	0	0	0	0	0	0	0	0
S20 - Dental Surgery	1	1	1	1	1	1	1	1
S24 - Maxillo-Facial Surgery	1	1	1	1	0	2	5	4
S25 - Otorhinolaryngology (ENT)	31	25	25	29	39	45	48	52
S30 - Gynaecology	5	6	8	9	15	21	22	28
S35 - Neurosurgery	2	3	0	1	2	1	1	1
S40 - Ophthalmology	5	6	7	6	10	11	16	18
S45 - Orthopaedic Surgery	259	244	234	230	227	222	225	241
S59 - Specialist Paediatric Surgery [Others]	0	0	0	0	0	0	0	0
S60 - Plastic Surgery [excluding burns]	29	30	29	27	27	22	20	23
S70 - Urology	12	14	12	13	8	14	16	16
S75 - Vascular Surgery	3	1	1	2	5	6	7	7
	360	**339**	**326**	**327**	**343**	**357**	**370**	**398**

SSED Performance

Short-Stay ED by from Q1 2022/23 to Q4 2023/24







Note:

- Dunedin is seeing a similar trend to other hospitals in the country, with triage levels 2 and 3 rising (higher acuity patients), and triage levels 4 and 5 falling over time.
- Their SSED is slowly rising, and (like other hospitals) the admitted patient cohort spends the longest in ED. Their non-admitted patients don't reach the 95% target, but they are often >80% (i.e. if you come into the ED and go home again, >80% of the time that will happen within 6 hours).
- They have been particularly challenged in the last month with high isolation requirements for respiratory illness, meaning that there are delays in transfer out of the ED and into the wards while isolation rooms are created. The new hospital will have a large proportion of single rooms which should help.
- SSED plan in place to reduce wait times and patient flow.
- Dunedin Hospital works closely with Invercargill to coordinate patient flow across the district.
- Regional networks in place to enhance service delivery and collaboration.
- The 'dip' in October and November 2023/24, can be attributed to missing data. This will be rectified in future iterations.

Initiatives underway to improve performance

66. In the past two years approximately 80 – 90 joint patients waiting over 365 days have had their operation in Timaru.

67. An additional acute session started on Saturdays from April 2024 to reduce acute pressure during weekdays. When staffing levels permit, we will run late acute sessions during weekdays.

68. Four ringfenced beds for orthopaedics opened in 2023, managed by Nurse Practitioners. Weekend physiotherapy assistants are employed to improve flow and discharge rate.

69. In September 2023 the HAA (high acuity area) was opened as a step down from ICU care. This has reduced the pressure on our ICU and the number of day surgery cancellations.

70. Southern is maximising outsourcing opportunities across the district, including to Mercy Hospital and Southern Cross Health.

71. The Filleul Street Surgical Centre was opened in April 2023 and provides Ophthalmology day surgery for eye patients in the wider Otago community. Working in partnership with Matua Healthcare Group, it is used by both the Dunedin Hospital Ophthalmology Department for public patients and local Ophthalmologists for private surgery. Because it provides day eye surgeries outside Dunedin Hospital, it frees up space in acute hospital theatres.

Appendix 1: Runsheet for visit to Dunedin Hospital on Thursday 20 June

Time	Details	Minister's Office notes
	Minister travels to Dunedin Hospital, 201 Great King Street. Please drive into the Emergency Department driveway on to the concourse. Your driver will be directed to an allocated car park.	
8:55am	Minister Reti* will be met by Hamish Brown (Group Director of Operations, Southern) and will be ushered by Nancy Todd & Bridget Dickson into seating in the entrance area to the Oncology area. * Hamish will be the Health NZ representative escorting the Minister on this visit, and also the later visits to the New Dunedin Hospital site and Te Kāika Wellbeing Hub.	
9:00am	Mihi from Matapura Ellison on behalf of Manawhenua, followed by waiata.	
9:05am	Minister Reti responds to manawhenua mihi followed by waiata (Nancy Todd and Bridget Dickson)	
9:10am	Hariru (elbow contacts) between Hau kāika and Ministerial group - no hongi element.	
9:15am	Move to refreshments onsite / offsite	
9:25-9:50am	The Minister and his delegation will be escorted to the Boardroom, Level 1, Psychology Services Building. The Minster will attend an online Teams meeting with Hamish Brown and Dr David Gow* (Chief Medical Officer, Southern). * David is attending the Regional Hospital and Specialist Services planning meeting in Christchurch.	
9:50-10:10am	Brief meet and greet with the local clinical leadership team including:	

	• Dr Hywel Lloyd (Director, Quality and Clinical Governance, Health NZ Southern & Te Kāika Project Governance Board) • Bridget Dickson (Programme Director, New Dunedin Hospital & Executive Leadership Team) • Craig Ashton (General Manager: Medicine, Women's, and Children's Health) • Melissa Law (Service Manager: Surgical Services and Radiology) • Jenny Hanson (Director of Nursing: Medicine) • Tracy Hogarty (Director of Allied Health) • Mr Philip Davis (Medical Director: Surgical Services and Radiology) • Dr Rebecca Brushwood (Medical Director: Women's and Children's).	
	The Minister and his delegation will next have a tour of Dunedin Hospital	
10:10am	Walk through the Hospital to the Operating Theatres, Level 5.	
10:15-10:30am	Meet with Dr Clarie Ireland (Anaesthetist), Mr Philip Davis (Medical Director: Surgical Services and Radiology) and Melissa Law (Service Manager: Surgical Services & Radiology). Tour the Operating Theatres and Central Sterilising Services Unit.	
10:30am	Walk to Southern Blood and Cancer Services (SBCS) Building.	
10:30-10:50am	Meet with Alison Aumata (Service Manager: Southern Blood and Cancer Service), Dr Louise Bremner (Medical Oncologist) and Therese Duncan (Associate Director of Nursing). Tour the SBCS: • Infusion therapy • Radiation Therapy Services • LINAC	

10.55am	Minister and his delegation depart Dunedin Hospital for the New Dunedin Hospital Project Management Office	

Briefing

Health New Zealand
Te Whatu Ora

Proactive release of New Dunedin Hospital Cabinet Paper

Due to MO:	1 August 2024	**Reference**	**HNZ00043820**
To:	Hon Dr Shane Reti, Minister of Health		
From:	Jeremy Holman, Chief Infrastructure and Investment Officer, Infrastructure and Investment Group		
Copy to:	n/a		
Security level:	In Confidence	**Priority**	Routine
Consulted	Ministry of Health		

Action sought	**Action required by**
Agree to proactively release the Cabinet Paper and Minute of Decision entitled "New Dunedin Hospital Cost Pressure funding"	2 August 2024

Contact for further discussion (if required)

Name	**Position**	**Phone**	**1st contact**
Blake Lepper	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)	

Purpose

1. This paper seeks your agreement to proactively release the Cabinet paper and Minute of Decision entitled “New Dunedin Hospital Cost Pressure funding” (March 2024) [CAB-24-MIN-0095.

Recommendations

Health New Zealand | Te Whatu Ora recommends that you:

a)	**Agree** to proactively release the Cabinet Paper and Minute of Decision entitled “New Dunedin Hospital Cost Pressure funding” (March 2024) [CAB-24-MIN-0095].	**Yes/No**

s9(2)(a)

Jeremy Holman

Chief Infrastructure and Investment Officer

Health New Zealand | Te Whatu Ora

Date: 01 August 2024

Hon Dr Shane Reti, Minister of Health

Date:

Discussion

2. The Cabinet paper “*New Dunedin Hospital Cost Pressure funding*” (March 2024) was approved by Cabinet on 25 March 2024 [CAB-24-MIN-0095].

3. Proactive release is in line with Cabinet Office circular *CO (18)4 – Proactive Release of Cabinet Material* requiring all Cabinet and Cabinet committee papers and minutes to be proactively released within 30 business days of final decisions being taken by Cabinet.

4. We delayed proactive release in anticipation of a Ministerial announcement on the additional funding for New Dunedin Hospital. This was consistent with Cabinet Office Circular CO (23) 04 25.1, whereby release can be delayed if there is a planned announcement (even after the 30-day period).

5. As the funding amount was considered commercially sensitive and could impact negotiations, it was not publicly announced. We have reviewed the Cabinet paper and Minute of Decision to ensure appropriate redactions are made (see Appendix 1).

6. We invite you to comment on the proposed redactions, including to suggest any others you consider should be made.

Risks

7. There will be a high level of public and media interest in the release of the Cabinet paper.
8. A large amount of information is already public, including through Official Information Act 1982 requests, media and Written Parliamentary Questions.
9. We also have several Official Information Act requests about to be released. These requests include the Cabinet paper, several briefings and the monthly Health Capital Update Report.
10. The Cabinet paper refers to the appointment of a Ministerial advisor. However, an appointment has not yet been made.
11. Publishing the Cabinet paper could lead to further Official Information Act requests for reporting to the Infrastructure Ministers and the enhanced monthly reporting being requested.
12. Also relevant to the release of the Cabinet paper is that Te Waihanga plan to proactively release the independent review. Te Waihanga are seeking Ministerial approval of the release.

Next steps

13. We look forward to any feedback you wish to provide on proposed redactions.
14. With your approval, the Cabinet paper and Minute of Decision will be published on our website.
15. We are preparing reactive messages to support the proactive release. These will be shared with your office.

Briefing

Health New Zealand
Te Whatu Ora

New Dunedin Hospital

Due to MO:	8 August 2024	**Reference**	**HNZ00058951**
To:	Hon Dr Shane Reti, Minister of Health		
From:	Jeremy Holman, Chief Infrastructure and Investment Officer		
Copy to:	Hon Chris Bishop, Minister for Infrastructure		
Security level:	In Confidence	**Priority**	Routine
Consulted	The Treasury, Ministry of Health, New Zealand Infrastructure Commission		

Action sought	**Action required by**
Direct: Health New Zealand to develop options to meet the existing appropriation of $1.880 billion for the design, construction and commissioning of the inpatients and outpatients building. **Agree** the following options can be considered by Health New Zealand, if considered necessary: • Option 1: Revision of specification and scope within the existing structural envelope • Option 2: Full redesign of a smaller facility on current new inpatient site • Option 3: Staged development on the old hospital site • Option 4: Staged development on Wakari site	15 August

Contact for further discussion (if required)

Name	**Position**	**Phone**	**1st contact**
Blake Lepper	Head of Infrastructure Delivery	S9(2)(a)	x
Jeremy Holman	Chief Infrastructure and Investment Officer	S9(2)(a)	

Purpose

1. This paper updates you on the actions taken since the Health New Zealand | Te Whatu Ora (Health NZ) Board (Board) endorsed the findings of the New Dunedin Hospital (NDH) Independent Review and updates you on emerging findings regarding project affordability.

Summary

2. The New Dunedin Hospital Independent Review highlighted that the approved budget for New Dunedin Hospital is likely to be insufficient to cover the current project scope
3. The end of the developed design was a critical point for understanding the budget position for the project. Health NZ have received a full elemental estimate from the projects Quantity Surveyor and the Target Outturn Cost 2 tender submission from the contractor. Both these numbers are above the current budget.
4. Our focus remains on trying to deliver the NDH within the current budget. However, Health NZ may need to consider downsized options in order to deliver the project within the current budget.
5. We are seeking direction from Ministers to work within the current capital appropriation for the project and on the parameters that Health NZ may consider when developing proposals to ensure the project is delivered within the government's budget expectations.
6. We have suggested four options which are detailed in the briefing below. These are:
    a. Option 1: Revision of specification and scope within the existing structural envelope
    b. Option 2: Full redesign of a smaller facility on current new inpatient site
    c. Option 3: Staged development on the old hospital site
    d. Option 4: Staged development on Wakari site.
7. There is currently limited information about the status of the NDH publicly available. This is creating concern amongst the community and clinical workforce. It is in the public interest that the challenges the project is facing are communicated in transparent way. We recommend that Ministers make a clear public statement of the parameters Health NZ has been instructed to work to

Recommendations

Health New Zealand | Te Whatu Ora recommends that you:

a)	**Note** the New Dunedin Hospital Independent Review highlighted that the approved budget for New Dunedin Hospital is likely to be insufficient to cover the current project scope.	**Noted**
b)	s9(2)(b)(ii), 9(2)(j) [redacted]	**Noted**
c)	**Direct** Health New Zealand to develop further options to meet the existing appropriation of $1.880 billion for the design, construction and commissioning of the inpatients and outpatients building.	**Yes/No**
d)	s9(2)(b)(ii), 9(2)(f)(iv), 9(2)(j) [redacted]	**Noted**
e)	s9(2)(b)(ii), 9(2)(f)(iv), 9(2)(j) [redacted]	**Noted**
f)	**Agree** the following options can be considered by Health New Zealand if considered necessary to develop a feasible design solution for the New Dunedin Hospital:	
	a. Option 1: Revision of specification and scope within the existing structural envelope	**Yes/No**
		Yes/No
	b. Option 2: Full redesign of a smaller facility on current new inpatient site	**Yes/No**
	c. Option 3: Staged development on the old hospital site	**Yes/No**
	d. Option 4: Staged development on Wakari site	
g)	**Note** that the development of all options will be driven by clinical needs and the benefits delivered to the community, along with considering whole of life costs.	**Noted**
h)	**Note** that the optimum delivery/procurement method is dependent on first determining the scope and scale of the build – there will be a range of commercial solutions for delivery, which should be considered following the completion of the work set out herein.	**Noted**
i)	**Agree** to forward this briefing to other relevant Ministers and seek their agreement to the course of action.	**Yes/No**

s9(2)(a) [redacted]

Jeremy Holman
Chief Infrastructure and Investment Officer
Health New Zealand | Te Whatu Ora
Date: 7 August 2024

Hon Dr Shane Reti, Minister of Health
Date:

Background

8. Health NZ has been progressing the New Dunedin Hospital in line with previously agreed Cabinet decisions on the scope for the facility. We have recently completed developed design, are 60-70% through the piling programme and have been focused on agreeing a construction contract for the Inpatient Building as soon as possible to maintain the project timeline and ensure that construction progresses without unnecessary delays.

9. Due to cost pressures, we are not confident (and haven't been for some time) in the ability to deliver the scope of the facility within the agreed budget. We have been working to agree a reset budget and scope for the facility. In March 2024, Cabinet agreed to hold funding in a new tagged contingency, from the DHB Equity Support Capital Contingency, to meet the estimated $290 million cost pressures funding requirement faced by NDH.

10. Cabinet directed an interim Implementation Business Case be developed for Joint Ministers approval ahead of contract execution and that drawdown of the funding is subject to Cabinet approval of the Implementation Business Case for NDH. At this time, Cabinet also agreed to additional assurance activities for NDH, including a one-off review facilitated by the Infrastructure Commission (CAB-24-MIN-0095 refers).

11. The findings of the review were accepted by the Board and implementation of the recommendations is underway. In particular, Health NZ has been focused on resetting the project governance structures and is in the process of appointing a new independent chair to the project steering group to provide additional leadership, guidance and assurance to the project.

12. Most significantly, the review highlighted that the approved budget for NDH is likely to be insufficient to cover the current project scope. This is exacerbated by ongoing cost escalations in materials and skilled labour, as well as the impacts of COVID-19 on the construction industry.

13. To achieve greater cost certainty, the review highlighted three key deliverables that would provide greater insight into the likely cost of the project:

    a. a developed design estimate from Health NZ's Quantity Surveyor

    b. the Target Outturn Cost 2 tender submission from the Contractor

    c. a robust Quantitative Risk Assessment.

14. These deliverables are expected to provide a more accurate and reliable cost estimate, aligning the budget with current market conditions.

15. Since the independent review was provided to Ministers, Health NZ has received the first two of these deliverables. These deliverables estimate that the project budget would likely need to increase by a further (approx.) s9(2)(b)(ii), 9(2)(f)(iv), 9(2)(j) (above the current appropriation and the $290 million tagged contingency) to deliver the Inpatient Building as currently designed. As a result of this information, Health NZ is now focused on reducing costs and delivering the project within the approved budget.

Discussion

Competing issues across the health estate

16. Health infrastructure is a critical enabler of our health care system and underpins $22 billion annual government expenditure on health services. Substantial Crown investment will be required in health infrastructure to deliver safe and resilient health facilities that also enable the more efficient and productive delivery of health care that reduces waiting times and ensures the delivery of the government's health targets.

17. Today we have a deficit of ~500 beds nationwide, which is seen most acutely in our major centres where hospitals are running at 100% capacity. While we are investing in hospital in the home and other transformation projects to provide care in non-hospital settings, continued demographic change will compound this pressure. Our modelling highlights that this growth is not spread evenly across the country: 41% of demand is in the Northern region, 23% in the Te Manawa Taki region, 15% in the Central region, and 21% in Te Waipounamu.

18. In addition to the capacity challenge, we also face issues with the condition of our buildings. Health infrastructure has suffered from years of underinvestment. Consequently, our network is made up of ageing physical infrastructure (1,200 buildings on 86 campuses) that is not always fit for purpose nor able to support modern healthcare practice, meaning much of our urgent investment needs are focused on remediating risk (e.g., seismic ratings) instead of adding capacity.

19. As an example:

    a. 48 buildings or 4 per cent are classified as earthquake prone (others not yet assessed may also be classified as earthquake prone) and many other buildings may not be able to function following a major earthquake; and

    b. 70 percent of mental health facilities do not meet therapeutic and safety requirements.

20. Health NZ recognises that the Government always faces greater challenges than there is funding available to solve. It is our role to advise on the difficult trade-offs that must be made to get the most effective use of limited Crown capital. s9(2)(g)(i) We seek a clear mandate from Ministers to develop options on scope, scale and timing of investment to maximise the benefit that can be derived from within this envelope.

Current focus on the NDH Project

21. Within the overall appropriation for the design, construction and commission of NDH, the construction contract sum for Inpatients Building is the most significant amount and therefore key to the overall affordability of the project. The budget for the Inpatients construction contract with the Main Contractor (CPB) was s9(2)(b)(ii), 9(2)(j) (out of a total budget of $1.88 billion). The broader scope and estimated costs of investment in the NDH programme are set out at Appendix 1.

[1] See Appendix for additional detail

22. The end of the developed design was a critical point for understanding the budget position for the project as Health NZ would receive a full elemental estimate from the projects Quantity Surveyor and the "Target Outturn Cost 2[2]" (TOC2) tender submission from the contractor.

23. Over the last two weeks, we have received both these numbers and as expected they are above the current budget. Health NZ's Quantity Surveyor (QS) number by s9(2)(b)(ii), 9(2)(f)(iv), 9(2)(j) and the Contractor TOC2 submission by s9(2)(b)(ii), 9(2)(f)(iv), 9(2)(j)

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

25. It will take time to work through the pricing details included in the QS and contractor submissions. These submissions are substantive and complex documents, and the project team needs to fully understand the nuances of what they are telling us about the true cost of these facilities.

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

27

Alternate options if the gap cannot be closed

28. While the focus remains on trying to deliver the NDH within the current budget, if the gap cannot be closed then Health NZ will need to consider downsized options in order to deliver the project within the current budget.

[2] The Target Outturn Cost is the contract sum in the Managing Contractor contract model proposed. It is the final cost that the contractor is indicating is a realistic price for the contract works. Under the contract model, the Contractor receives an increased profit if they deliver the project for less than the Target Outturn Cost so it was expected that the submission would be slight conservative compared with the QS estimate.
We refer to Target Outturn Cost 2 as the overall pricing submission was presented in two parts. s9(2)(b)(ii), 9(2)(j)

29. Prior to Health NZ, districts would develop their own local Clinical Service Plans. Since 2016, significant clinical service planning, capacity modelling and capital planning was undertaken to inform the development of the NDH. Over this time several reports were commissioned with methodologies and outputs evolving as the NDH project planning progressed through the Business Case framework.

30. In response to the Independent Review findings and the likely cost challenges, Health NZ had already started planning for a review of these documents and how they have been applied to the NDH project. This includes carrying out a review of:

    a. the scope of the new build and the appropriateness of scale considering more contemporary models of care and updated information on the future demand for services across the region

    b. the integrated approach to all services across the site

    c. how services will function in the wider scope of the Southern District including its relationship to Invercargill, the expanding population of the Lakes District and the role of Christchurch Hospital.

31. In 2023, as part of the National Clinical Service and Campus Plan development, a methodology was developed to understand the bed capacity requirements for the future across the country. This methodology and international functional benchmarks were used to develop a nationwide approach for demand and capacity modelling to inform service planning and hospital rebuild programmes[3]. This allows us to compare the need of Dunedin in a nationally consistent model with the same benchmarks we are using to develop other projects around the country.

32. In addition to the updated modelling, there is a need to complete a Clinical Services Network Plan for the wider Southern Te Waipounamu area. The use of distributed networks to deliver specialist care, redefining the levels of care provided at all facilities across Te Waipounamu to support more affordable and sustainable models of service delivery. This is particularly prompted by the interest in Wanaka/Queenstown who are seeking a clearer health service delivery commitment from Health NZ.

33. There is strong clinical leadership for the Dunedin Hospital build and the Otago Region. This leadership has a significant role to play in the rapid clinical review process.

34. It is possible that the outcomes of the cost and clinical services review call for a different design response[4] than that currently anticipated by the project. It will not be clear until we have completed to work what outcome might be the most feasible and efficient. However, we are keen to test the acceptability of different design responses with Ministers.

[3] The nationally consistent methodology utilises past activity and utilisation rates with Statistics New Zealand Medium population projections to predict need and functional benchmarks are then applied to the demand projections to translate into future capacity requirements. The functional benchmarks are based on the National Campus and Service Plan (beds) or well-established Australian state benchmarks utilised in major capital

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

35. Broadly we consider the design responses are likely to come from the range of options that have been considered previously. These are discussed briefly below:

Option 1: Redesign within existing envelope

- Under this option, the NDH project would seek to evaluate the allocation of space within the current overall Inpatients Building design.
- This is similar to the approach that was taken with the previous design reset.
- The advantage of this approach is that it maximises the use of existing design work and could potentially allow some site works to continue on the current programme. However, this approach limits the options for value management and therefore means all savings need to be found from a reduction of clinical space or a reduction in future capacity (the building has been designed to accommodate anticipated growth to 2043). As a result, more services may need to be reduced to achieve the required savings and the resulting design may not be operationally optimised.

Option 2: Redesign from first principles on current site

- Under this option the project team would continue to work based on the current site but reset the design to first principles with a revised scope and schedule of accommodation.
- Time would be lost resetting the design. However, a smaller building would reduce construction time and therefore the overall time to opening may not be as significantly impacted.
- Reducing the size of the inpatients building would not negate the need to find facilities for those services removed from the facility and these would need to either be located within existing facilities and/or relocated within the community. The costs associated with this would need to be considered as part of assessing the feasibility of this option. This potentially also creates operational challenges if services ultimately get split across three campuses.
- Finally, this option does not resolve many of the issues with the current site that have driven cost into development and limit the future flexibility of the campus.

Option 3: Redevelop on or adjacent to the existing site

- Under this option the project team would focus on developing a design that maximises the reuse of the existing facilities and prioritises new build investment only for those services that are in most acute need of redevelopment.
- The business case for NDH focused on the critical condition of key buildings on the existing campus, particularly the Clinical Services Building. However, other buildings on the campus, including the existing ward tower have greater economic life and could potentially be refurbished.

- A smaller Clinical Services building, built on an adjacent site to enable the decant and demolition of the existing clinical services building could enable the resolution of Dunedin most significant infrastructure issues with a lower portion of new build facilities.
- As with all “brown field” developments the risks with working in close proximity to existing services is challenging and would need to be carefully understood. This option would also require the purchase and demolition of buildings to create development space.

Option 4: Redevelop at Wakari site

- One of the options contemplated in the Indicative Business Case was a greenfield development on the Wakari Hospital site.
- The Wakari site is a 16ha site owned by Health NZ. It is situated in the suburb of Wakari, about three kilometres north-west of the city centre.
- The Wakari site could potentially enable a much more flexible approach to development. The size of the site enables a different approach to building form and function that could potentially lower construction costs and enable a progressive approach to development that could evolve over time. While the site can have challenging access on the coldest days, at other times of the year the additional parking creates good accessibility for those travelling from outside of the region and has space for complimentary development.
- The greatest challenge for this option would involve how to manage breaking the existing connections between the hospital and the city centre and University.

36. As part of options 2-4 consideration could be given to complimentary investment in either further supporting infrastructure across Central Otago and Southland or in digital technologies that could better enable care closer to home and further reduce the scale of physical infrastructure required to be built in Dunedin to offer the same level of care.

Financial implications

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

38.

39.

Next steps

40. There is currently limited information about the status of the NDH publicly available. This is creating concern amongst the community and clinical workforce. It is in the public interest that the challenges the project is facing are communicated in transparent way.

41. We recommend that Ministers make a clear public statement of the parameters Health NZ has been instructed to work to. This should include announcing the additional tagged contingency approved by Cabinet in March 2024, releasing the Cabinet paper and independent review, and providing a clear statement about the expectation that Health NZ work to the revised budget and develop solutions within this envelope.

42. Health NZ will work with the Treasury and Ministry of Health officials to prepare these supporting documents for proactive release. The proposed redactions on the Cabinet paper have already been provided to your office for consideration.

Appendix 1: Clarifications on NDH Budget

As a matter of good practice, a business case for an investment should present a complete understanding of the capital, revenue, and whole of life costs of the proposed initiative.

Unfortunately, the business case for the New Dunedin Hospital principally related to the design, construction and commission of a new inpatients and outpatients building. Some costs inherently associated with the investment are accounted for in other businesses cases; other costs were noted as out of scope and not presented at all.

The division of funding decisions under the old system has resulted in decisions being made with only a partial picture of the total investment required. Considerable effort has been made to improve the understanding of all aspects of the investment. However, there remains significant divergence in maturity and accuracy of different elements of the overall investment picture.

Overall scope of investment

The broader scope of the NDH programme of works includes:

- the NDH Facilities (Outpatients and Inpatients)
- the Data and Digital investment as defined in the Final Data and Digital Detailed Business Case
- the additional operating and finance costs associated with the new facilities (subject to a Business Case being developed)
- the future funding requirements, that is items that are not part of the original NDH business case but are important to project completion, such as the pathology laboratory development, additional carparking and the reuse/decommissioning of buildings at the former hospital.

The following table summarise the best information to date on the overall costs of the investment required in Dunedin. Further detail on the assumptions behind these numbers are available from the project team.

	Approved Funding[5]	**Estimated Future Funding Requirements[6]**
NDH Facilities (Outpatients and Inpatients)	$1,880m	
Data and Digital	$225m[7]	
Pathology Lab (estimate)		$45m
Refurbishment/Demolition existing facilities (estimate)		$325m
Carparking (estimate)		s9(2)(b)(ii), 9(2)(f)(iv)
s9(2)(b)(ii), 9(2)(f)(iv)		
	$2,105m	

[5] This funding has been agreed but has not have been released in full.
[6] These are current high-level estimated costs only.
[7] $225 million budget approved. $69 million has been drawn down for the Outpatients Building with the balance subject to an additional business case.

Estimated Annual operating costs	
Additional Workforce	$ 108m[8] per annum
Additional utilities, maintenance, depreciation	Not yet quantified

NDH Facilities budget

The NDH Final Detailed Business Case principally relates to the detailed design, construction and building commissioning of the NDH, comprising an Inpatient Building and an Outpatient Building. This section summarises the components of the project captured within this budget and the NDH Facilities line in the table above.

The following table summarises the various components of this budget and the cost incurred to date against each of these line items.

Level 1 Breakdown *(Level 2 Breakdown)*	Current estimate ($)	Job to Date ($)
s9(2)(b)(ii)		
Outpatients Building	9(2)(b)(ii)	139,025,627
s9(2)(b)(ii)		
Inpatients Building	9(2)(b)(ii)	90,506,301

[8] These are current high-level estimated operating costs as signaled in the briefing *Options relating to the continued delivery of New Dunedin Hospital* of 26 January 2024.

s9(2)(b)(ii)

Totals	**1,880,000,000**	**394,565,464**

Briefing

Health New Zealand
Te Whatu Ora

NDH Update to Address Budget Challenges

Due to MO:	12 September 2024	**Reference**	**HNZ00064655**
To:	Hon Dr Shane Reti, Minister of Health		
From:	Jeremy Holman, Chief Infrastructure and Investment Officer		
Copy to:	Hon Nicola Willis, Minister of Finance, Hon Chris Bishop, Minister for Infrastructure, Hon Shane Jones, Minister for Regional Development		
Security level:	Sensitive	**Priority**	Urgent
Consulted	The Treasury, the Ministry of Health and the Infrastructure Commission		

Action sought	**Action required by**
Agree that Health New Zealand can begin consultation with critical stakeholders including the Dunedin City Council and the University of Otago on the options progress the New Dunedin Hospital to budget. Consultation will ensure we have a clear understanding of the benefits and risks before a final decision is made on the way forward.	20/09/2024
Agree that an Implementation Business Case for the Inpatients Building will be provided later this year for Cabinet approval	20/09/2024

Contact for further discussion (if required)			
Name	**Position**	**Phone**	**1st contact**
Blake Lepper	Head of Infrastructure Delivery	s9(2)(a)	x

Purpose

1. This paper updates you on two options for the design, construction and commissioning of the New Dunedin Hospital (NDH) within the existing budget of $1.880 billion.

2. We require your agreement for Health New Zealand | Te Whatu Ora (Health NZ) to begin consultation with critical stakeholders to support these options subject to your announcement planned for 26 September 2024.

Summary

3. In August, you noted that the initial pricing received from the preferred contractor, CPB, confirms the budget challenge highlighted in the Independent Review. s9(2)(b)(ii), 9(2)(f)(iv), 9(2)(j)

4. You directed Health NZ to develop further options to meet the existing budget for NDH.

5. Following advice from Health NZ in August [HNZ00058951 refers], you agreed that four options can be considered by Health NZ to develop a feasible design solution for the NDH. Of the options presented two present a viable pathway forward to keeping the project on budget:

   a) Revision of the existing design on the current site.

   b) Staged development on the existing campus.

6. Both options will seek to achieve cost savings by making greater use of existing assets to reduce the amount of new building required. To confirm the viability of these options, it is important that we revisit the master planning for the project to ensure the proposals will deliver operationally efficient outcomes and still enable appropriate future development opportunities. We have started this work and will continue to progress redesign and planning to support both options and seek your endorsement on a preferred option in the coming months.

7. We are also due to provide an Implementation Business Case to Cabinet later this year and consider that following your consideration, this Implementation Business Case is the way to seek final agreement on the preferred option.

8. We will continue transition planning for the opening of the Outpatients building currently in construction, including workforce planning, to ensure that we continue to care for staff working at the existing hospital site.

9. To progress the options development, we also recommend increased communications and stakeholder engagement on project status and our plans for delivery of the NDH infrastructure and health services. We are seeking your agreement to engage with the Dunedin City Council and the University of Otago following your announcement (planned for 26 September). This engagement will ensure we have a clear understanding of the benefits and risks of both options before a final decision is made.

Recommendations

Health New Zealand | Te Whatu Ora recommends that you:

a)	**Agree** that Health New Zealand can begin consultation with critical stakeholders including the Dunedin City Council and the University of Otago on the options to progress the New Dunedin Hospital to budget. Consultation will ensure we have a clear understanding of the benefits and risks before a final decision is made on the way forward.	**Yes/No**
b)	**Agree** that an Implementation Business Case for the Inpatients Building will be provided later this year for Cabinet approval.	**Yes/No**

Hon Dr Shane Reti, Minister of Health

Date:

Hon Nicola Willis, Minister of Finance

Date:

Hon Chris Bishop, Minister for Infrastructure

Date:

Hon Shane Jones Minister for Regional Development

Date:

Jeremy Holman

Chief Infrastructure and Investment Officer

Health New Zealand | Te Whatu Ora

Date:

Background

10. Health NZ has been progressing the NDH in line with previously agreed Cabinet decisions on the scope for the facility. We have recently completed developed design, are 60-70% through the piling programme, and have been focused on agreeing a construction contract for the Inpatient Building.

11. In August, we advised the initial Target Outturn Cost 2 (TOC2) Pricing received from CPB confirms the budget challenge identified in the Independent Review [HNZ00058951 refers]. We further advised that delivering to budget may require a rescope and redesign of the Inpatient building and delay the opening date. We also advised that in developing options to deliver on budget we may need to revisit decisions on site and masterplan.

12. On 10 September, we met with the Minister for Infrastructure to provide an update on the work completed and progress towards an on-budget option. At that meeting, this briefing was requested to update relevant Ministers on progress and support a planned announcement by the Government on the current state of the project and anticipated next steps. This announcement is scheduled for 26 September 2024.

We have been working with CPB to close the budget gap

13. In August, you noted that the initial TOC2 Pricing received from CPB confirms the budget challenge identified in the Independent Review [HNZ00058951 refers]. Both Health NZ's Quantity Surveyor (QS) number and the Contractor's TOC2 submission are above budget by s9(2)(b)(ii), 9(2)(j)

14. Over the last four weeks we have been working through the pricing details received in the QS and Contractor submission and working closely with CPB to reduce the gap between the current estimate completion cost and the project budget.

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

16. We have made significant progress to reducing the cost of the current design option. This will be confirmed when the TOC2 is resubmitted on the 16 September. s9(2)(b)(ii), 9(2)(f)(iv), 9(2)(j)

We are progressing two options to keep NDH within budget

17. The gap cannot be closed through commercial and engineering negotiations alone and a rescope and redesign is required.

18. We have narrowed the options for consideration from four to two. We do not consider Options 2 and 4 to be optimal and are proposing discounting them for the reasons discussed below:

a) Option 2: Full redesign of a smaller facility on current new inpatient site:

   i. To make financial sense, Health NZ would need to have confidence that a full redesign could find sufficient cost savings to overcome the cost incurred as a direct result of the time and effort associated with the redesign work. The Clinical Services Review has not identified any aspects of the current design that are so significantly over scoped that they would provide this necessary offset. While some areas could justifiably be reduced, these savings can mostly be realised through a reallocation within the current design.

   ii. Many of the challenges the project has faced relate to the current site selection. Due to the site being in a flood plain (with poor geotechnical conditions, access, and expansion space), significant construction costs need to be built into any project in this location which challenges the value for money of a smaller structure on this site. Most strategies to reduce the construction cost would involve consideration of alternative sites.

b) Option 4: Staged development on Wakari site:

   i. The Wakari Hospital site, located on the hills above the city centre, has good redevelopment potential with significant capacity for a staged development of a new hospital to meet long term needs. However, this option is isolated from the central city and the benefits of integrating a hospital campus with the University will be lost. This option would be a start-from-scratch approach (site investigations, demolition etc), which would provide less certainty over timeframes for bringing new health services to Dunedin, along with transition planning being more difficult. These factors combined with the loss of co-location benefit with the University means we do not recommend further investigation of this option.

19. We are progressing Options 1 and 3 for further investigation.

20. In August, we appointed the new Independent Chair of the Project Steering Group, Rebecca Wark. Rebecca undertook site visits across the new and existing campus and met with people involved with the project. Rebecca has endorsed pausing the programme and running parallel workstreams to consider Options 1 and 3.

21. Both Options 1 and 3 will require some masterplanning of the existing hospital site to identify the buildings that are end-of-life and opportunities for refurbishment to continue delivering health services at the existing site.

22. The Clinical Services Review considers the health services requirements for Dunedin in the context of the wider regional services planning and will inform both Options 1 and 3. The strong clinical leadership for the Dunedin Hospital and Otago region will have a significant role to play in this clinical review process.

Option 1: Redesign within the existing structural envelope is underway

23. This option has been developed by the NDH Project team, working with CPB and local clinical team, alongside the pricing review. As part of the process the team has been focused on identifying:

    a) Floor areas within the building that can be reduced (broadly by removing a floor from the current design).

b) Additional areas that could be shelled to reduce the initial construction cost and fitted out later when demand requires them.

c) Services that could be retained on the existing campus or located in other buildings owned by Health NZ within Dunedin.

d) Revisiting design to the supporting energy infrastructure to find more cost-effective solutions.

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

25.

Option 3: Masterplanning for staged development on the old hospital site is underway

26. s9(2)(g)(i) alternative option would involve a design that focused on maximising the use of the existing campus, refurbishing the existing Ward Tower and developing a new Clinical Service Building on an adjacent site.

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

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31.

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

We will continue to progress investigations into both options and will report back to you in the coming months

33. In March 2024, Cabinet agreed to hold $290 million funding in a new tagged contingency, from the DHB Equity Support Capital Contingency, to meet the estimated cost pressures faced by NDH.

34. Cabinet directed an interim Implementation Business Case be developed for Joint Ministers approval prior to the drawdown of this contingency. This was targeted to be provided by December 2024.

35. Health NZ considers that the Implementation Business Case is the appropriate format to present the outcomes of this options analysis process. We seek agreement to continue to work on developing both options over the coming months and report back to you for your endorsement ahead of final Cabinet agreement.

36. Alongside the development of both options, we will be prioritising the planning for opening the new Outpatients buildings which is planned for completion at the end of 2026. This new infrastructure is a key part of the NDH and will make a tangible difference to delivery of planned care in the Southern Region. s9(2)(f)(iv), 9(2)(g)(i) [redacted]

Progressing the above options will require stakeholder, community, and frontline staff engagement

37. There is limited information publicly available about the status of the NDH. This is creating concern amongst the community and clinical workforce. It is in the public interest that we communicate the challenges the project is facing in a transparent way.

38. Subject to your announcement planned for 26 September, we are seeking your agreement to start engagement with the Dunedin City Council and the University of Otago. In particular, we want to ensure the revised masterplanning and assessment of either option takes into account city planning and maximises partnership with the University on the co-location of health, research and education and on the use of land and buildings.

39. We consider an increased effort is required in the communications and stakeholder engagement on where the project is at and our plans for delivery of the NDH infrastructure and services. We will be applying extra resource to this. A key consideration for Health NZ is to care for our staff who are working in the existing hospital and to respect the need for certainty and commitment to a way forward.

Financial implications

40. Costs for progressing Options 1 and 3 will be accommodated within the current appropriation. s9(2)(f)(iv), 9(2)(g)(i)

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

42. We are taking proactive steps to reduce project costs while the options analysis work is completed. Despite this any change to the current scope and design of the NDH will incur abortive design costs.

Next steps

43. As directed by Cabinet we will keep you updated monthly with the work we are progressing and any emerging findings.

44. We will report back in the coming months with a recommendation for your agreement on the way forward for the NDH. Design can then start on the infrastructure solutions alongside an Implementation Business Case for Cabinet approval.

45. Following your announcement planned for 26 September and your agreement, we will engage with the Dunedin City Council and the University of Otago.

46. We will continue to prepare an Implementation Business Case for Cabinet approval later this year.