West Coast District Health Board

Te Poari Hauora a Rohe o Tai Poutini

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8 June 2021

9(2)(a) [redacted]

[redacted]

[redacted]

RE Official information request WCDHB 9538

I refer to your email dated 31 March 2021 requesting the following information under the Official Information Act from West Coast DHB. Specifically:

- **All reports, minutes, plans, emails and other correspondence relating to the business case for a new mental health facility in Greymouth.**

Please refer to the attached **Appendix**, which contains reports, plans and correspondence relating to the business case for a new mental health facility in Greymouth.

Please note: We have redacted or withheld information pursuant to the following sections of the Official Information Act, where the withholding of the information is necessary to:

Section	Withholding Ground
s. 9(2)(a)	*to protect the privacy of individuals*
s. 9(2)(b)(ii)	*to protect information where the making available of the information would be likely to unreasonably prejudice the commercial position the person who supplied it or is the subject of the information*
s. 9(2)(g)(i)	*maintain the effective conduct of public affairs through – the free and frank expression of opinions*
s. 9(2)(j)	*enable a Minister of the Crown or any public service agency or organisation holding the information to carry on, without prejudice or disadvantage, negotiations*

Please also note: that the West Coast DHB Board, in discussion with the Ministry of Health, has since instructed management to revisit the options proposed in the business case. This is to explore in more depth other new build options, site, and what refurbishment of the current facility may look like. In addition, we are repeating the seismic assessment of the current building along with a condition assessment. This means that the June 2020 business case and options (including architectural design, size and layout) previously put forward will likely change and have therefore been withheld so as not to prejudice the outcome of this process and subsequent discussions to occur between the West Coast DHB Board and the Ministry of Health. We anticipate the revised business case being put forward for consideration in the third quarter of 2021.

I trust this satisfies your interest in this matter.

You may, under section 28(3) of the Official Information Act, seek a review of our decision to withhold information by the Ombudsman. Information about how to make a complaint is available at www.ombudsman.parliament.nz; or Freephone 0800 802 602.

Please note that this response, or an edited version of this response, may be published on the West Coast DHB website after your receipt of this response.

Yours sincerely

Ralph La Salle
Acting Executive Director
Planning, Funding & Decision Support

Appendix

West Coast
– District Health Board –
Te Poari Hauora a Rohe o Tai Poutini

West Coast DHB Mental Health Facility

Functional Design Brief

June 12, 2020

Mental Health Facility

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Project Manager:	Mark Newsome
Author:	9(2)(a) [redacted]
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Document history and status

Revision	Date	Description	Author	Checked	Reviewed	Approved
V1.0	15/5/2020	Draft Issue	[redacted]	[redacted]		
V2.0	29/05/2020	Feedback inclusions - Final Draft Issue	[redacted]	[redacted]		
V3.0	05/06/2020	Final Issue	[redacted]	[redacted]		
V4.0	12/06/2020	EMT feedback incorporated. Final Issue v2	[redacted]			

Contents

Glossary of terms and abbreviations

When we say	We mean
AHFG	Australasian Health Facility Guidelines
Ambulatory care	Care provided on an outpatient basis, including diagnosis, observation, consultation, treatment, intervention, and rehabilitation services.
AOD	Alcohol and Other Drugs of Addiction
CAMHS	Child and Adolescent Mental Health Services
Concept Design	The initial design idea, this stage generally takes place following a feasibility study and options appraisals, and is represented by blocking and stacking architectural drawings. This documentation and information will be used to develop an indicative business case. The plan establishes the areas of a site/s where future development would occur (in line with service requirements). The plan incorporates: service map with precincts identified for future development service activity zones within a precinct for example proposed uses, co-location proposals main transport routes to the site and within the site block drawings (at department level) of the proposed buildings including scale and footprint.
Consumer Journey	Description of the sequence of events and locations a consumer interacts with as part of accessing the health service
DHB	District Health Board
FTE	Full time equivalent
Functional Relationship	Defines the required physical relationships and movement between different areas of the Facility. The relationships describe: • the required patient, staff and clinical adjacencies and movements to support the model of care and patient journey

	• the required staff and non-clinical adjacencies and movements to support the model of service delivery • the required public movements throughout the Facility to support security and effective running of the healthcare services. Relationships will be referred to as internal and external
IFHC	Integrated Family Health Centre
IPU	Inpatient Unit
MHAS	Mental Health and Addictions Service
Model of Care	Is a multifaceted concept which broadly defines the way in which care is delivered including: • values and principles • roles and structures • the care management and referral processes Where possible the elements of a model of care should be based on best practice evidence and defined standards and provide structure for the delivery of health services and a framework for subsequent evaluation of care.
NGO	Non-Government Organisation
Patient Flow	The typical movements of a patient through the hospital from arrival to discharge in a given scenario
Primary care	Primary care refers to the work of health professionals who act as a first point of consultation for all patients within the health care system. Primary health care covers a broad range of health services, including diagnosis and treatment, health education, counselling, disease prevention and screening. The health professional would usually be a primary care physician, such as a general practitioner or family physician.
Role delineation	The New Zealand Role Delineation Model (NZ-RDM) has been developed to differentiate complexity between services within, and across District Health Board providers. The model creates specialty service capability levels based on key determinants that can be used to describe and understand patient services across the region. Key determinants of the RDM include: • hours of access • clinician characteristics • inter-specialty relationships • patient characteristics • key procedures or treatments
Schedule of Accommodation	A detailed spreadsheet listing all rooms including floor area and allowances for circulation (within departments), plant, and travel (between departments) resulting in the area in metres squared necessary to support the functional requirements of the building.
Secondary care	Medical care provided by a specialist or facility upon referral by a primary care physician that requires more specialised knowledge, skill, or equipment than the primary care physician can provide. Secondary care includes acute care: necessary treatment for a short period of time for a brief but serious illness, injury or other health condition.

1. Introduction

1.1 Structure

The structure of this facility brief covers three aspects of the planning and design process:

a) Model of care

b) Planning needs

c) Design requirements.

1.2 Model of care

The model of care for the Mental Health Facility is described in Sections 3 Service Description through to Section 8 Innovation and will appear as:

a) A description of the services delivered at the Mental Health Facility including its role within the local treatment system and regionally across the West Coast.

b) The scope of the service including its potential scope in the future.

c) The consumer's treatment journey acknowledging linkages within community and hospital settings.

d) Operational principles which are specific to the service and describes how the service intends to operate.

e) Staffing model and proposed workforce profile.

f) Innovative systems and processes and model of care.

1.3 Facility planning

Facility planning requirements are described in Sections 9 and 10 appearing as:

a) External and internal functional groupings and relationships. These same functional groupings will also be reflected in the Schedule of Accommodation.

1.4 Specific design requirements

Specific design requirements are described in Sections 11 and 12 appearing as:

a) Design principles and approaches, plus specific design requirements relevant to the Mental Health Facility.

b) Mental Health Facility Schedule of Accommodation (SoA).

2. Background

This Functional Design Brief has been prepared for the West Coast District Health Board as an input into a proposed Business Case for the development of a new Mental Health Facility on the Grey Base Hospital site to replace the existing earthquake prone building.

The site master planning activities undertaken in 2019 included an analysis of preferred options in relation to site planning principles to identify a preferred site for the new Mental Health facility along an escarpment adjacent to existing transitional care cottages.

A concept design process was undertaken in 2020 with focussed inputs from WCDHB and consultants to inform concept design requirements for the New Mental Health facility. Consultation with stakeholders was limited to videoconference and telephone due to travel restrictions in light of Covid-19.

3. Service Description

3.1 Summary

a) Since 2010, West Coast DHB has shared executive and clinical services with the Canterbury DHB. This includes a joint Chief Executive and clinical directors, as well as shared public health and corporate service teams. West Coast mental health consumers may be transferred for specialist tertiary level care and specialist appointments, some using tele-health technology.

b) The WCDHB Mental Health and Addictions Service (MHAS) strategic direction is to:

   i. offer care as close to people's homes as possible, and

   ii. strengthen and broaden the relationship with Canterbury Mental Health services.

c) The future model of care for WCDHB MHAS is informed by the WCDHB Mental health and Addictions Service Review (2014) and Mental Health and Addiction Services on the West Coast Model of Care (2017).

d) The model of care provides a stepped care approach across primary, community and specialist services. A Coast-wide approach provides locality-based integrated comprehensive services across the district supporting consumer care as close to home as appropriate. Close coordination and collaboration with centralised acute inpatient services occurs to support successful transition to and from the community for consumers requiring a higher level of care during acute episodes.

e) The MHAS will provide specialist clinical services within the Mental Health Facility, and MHAS and Child and Adolescent Mental Health Service (CAMHS) outpatient clinics primarily from the Grey Base Hospital and Integrated Family Health Centre (IFHC).

f) West Coast MHAS should be:

   i. Person centric

   ii. Recovery orientated

   iii. Provided in a therapeutically enriching environment

   iv. Integrated and coordinated across the continuum

   v. Provided in a setting that respects and can accommodate a diverse range of cultural and population care needs.

g) The collocation of the inpatient unit and community teams within the Mental Health Facility provides opportunity to enhance integration, collaboration, and support across teams leading to best possible outcomes for consumers.

h) The Mental Health Inpatient Unit (IPU) will provide resources for the delivery of short to medium term inpatient assessment and treatment services for people, typically aged 18 to 64, experiencing moderate to severe episodes of mental illness who cannot be adequately treated in a less restrictive environment or community based setting.

i) The acute inpatient care episode will provide seamless pathways from community care to acute mental health care, to transitional subacute and recovery-based services and community care.

j) While there are specialised clinical needs within the IPU, bed spaces should be adaptable and flexible wherever possible to provide for a range of care types during periods of fluctuating activity.

k) Treatments and models of care will change in line with the needs of the population of the West Coast DHB. It will be of vital importance that the inpatient physical environment is flexible and can adapt over time in response to changes in practice and treatment.

3.2 Planning framework

3.2.1 National, regional context

The following standards and guidelines, national policies, plans and priorities impacting Mental Health and Addiction Services include:

a) He Ara Oranga : 2018 Report of the Government Inquiry into Mental Health and Addiction. A total of 40 recommendations were made within the report, applying to health, the wider social sector and society as a whole.

b) Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012-2017.

c) Ngai Māori insights for A Kaupapa Māori Primary (Community) Mental Health and Addictions Service Model: The analysis. The Kaupapa Māori thematic analysis identified 23 themes of relevance to a Kaupapa Māori Primary Mental Health and Addictions service model.

d) He Tapu te Oranga o ia Tangata: Suicide Prevention Strategy 2019–2029 and Suicide Prevention Action Plan 2019–2024 for Aotearoa New Zealand.

e) Ministry of Health targets provide clear and specific focus for action to ensure health care services of the highest quality are delivered within the best possible time. A target for shorter stays in emergency departments is dependent on efficient provision of acute care and consumer pathways throughout the hospital facility ensuring hospital inpatient beds are available when emergency department treatment is completed.

3.2.2 Standards and guidelines

a) Mental Health (Compulsory Assessment and Treatment) Act 1992.

b) The Substance Addiction (Compulsory Assessment and Treatment) Act 2017.

c) Hospitals are required to meet the NZ Health and Disability Services Standards 2008.

d) The health and disability services standards are mandatory for those health and disability service providers that are subject to the Health and Disability Services (Safety) Act 2001. Their application will promote good and safe practice by providers.

3.2.3 Local context

a) The Mental Health Facility will be a stand alone building on the Grey Base Hospital campus and will provide centralised Mental Health and Addiction specialist services for the population of the WCDHB including:

   i. Acute mental health and addiction inpatient care

   ii. Crisis response including intensive community care

   iii. Complex Alcohol and Other Drug (AOD) services and co-existing disorders

   iv. Infant Child and Adolescent Mental Health Services (iCAMHS)

   v. Māori Mental Health

b) Ambulatory and Outpatient care for MHAS and iCAMHS will primarily be provided from the Grey Base Hospital Integrated Family Health Centre (IFHC) or in community settings. Community teams will be based at the Mental Health Facility supporting integration and collaboration across teams.

c) Some consumers may require more intensive therapies and care, therefore the WCDHB will maximise utilisation of networking relationships with other facilities providing inpatient mental health and addictions services in Christchurch, Blenheim, and Nelson.

d) Inpatient care for mental health and addiction services will be provided within an inpatient unit. Bed modelling completed by Sapere in May 2020[1] supports the provision of 8 inpatient beds which provides sufficient bed capacity through to the modelling horizon year of 2038. Inpatient beds will comprise 6 beds which may be paired or clustered to provide for different cohorting, and one pod of 2 beds for high needs care.

e) Modelling of future workspace requirements was undertaken in collaboration with the MHAS Clinical Manager as part of the concept design process to determine the number and types of workspace required based on future work roles and activities.

f) The Mental Health Facility environment will acknowledge and enable the four dimensions of Māori wellbeing as described in Mason Durie's Whare Tapa Whā model:

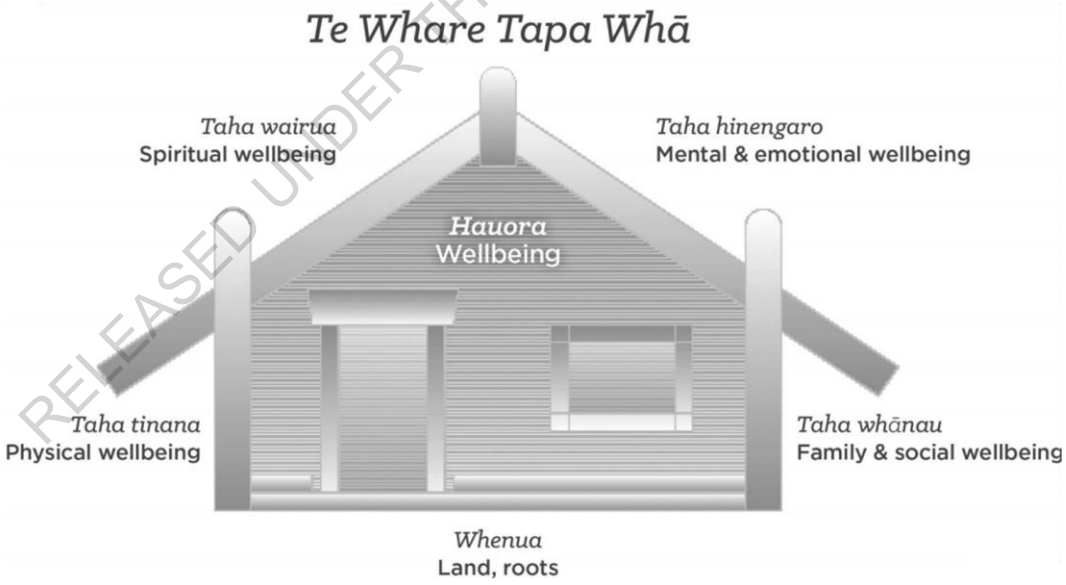
   i. taha tinana (physical wellbeing)

   ii. taha hinengaro (mental wellbeing)

   iii. taha wairua (spiritual wellbeing)

   iv. taha whānau (family wellbeing).

Figure 1: Te Whare Tapa Whā Model



[1] 2020. Sapere. West Coast mental health unit bed modelling.

4. Scope of Service

4.1 Capability

a) The Mental Health and Addictions Service will function within its service scope as defined within the published New Zealand Role Delineation Model (NZ-RDM), 2009 Rev 2014.

4.2 Functions

4.2.1 Community Mental Health Services

b) Community MHAS teams will be based within the Mental Health Facility including:

i. Adult Community Service - provide assessment and treatment in a community setting for clients with moderate-to-severe mental illness.

ii. Crisis response / Case management - provide advice for general inquiries related to mental health concerns, crisis response, assessment and support for people in their homes, respite options/access as well as assist to facilitate an admission into the mental health unit.

Child and Adolescent Mental Health Services (CAMHS) - assess and treat children and teenagers up to 18 years old with serious mental health disorders, suspected psychiatric disorders, and psychological disorders.

iii. Alcohol and Other Drug Services - assist people to access a range of support services related to community living such as education, vocational and social, as well as alcohol and drug rehabilitation services. Emphasis is placed on integration into the community and access to community based rehabilitation options such as specialist or cultural assessment and social work.

iv. Maori Mental Health Team - provide clinical and cultural services for all areas of mental health on the West Coast.

c) Outpatient activity may be supported within the Mental Health Facility if sufficient and appropriate accommodation is not available in the IFHC.

d) Consumers may present to the Mental Health Facility from time to time without prior arrangement. Community teams may provide responsive consumer support within the facility at these times.

4.2.2 Inpatient Services

Inpatient services will be available for those who need this level of intervention, but the focus will be on getting people back into their own community as quickly as possible with the necessary supports from primary and community services to prevent readmission. Mental Health Inpatient services will provide the following core functions:

a) Consumer cohort typically includes people aged 18 to 64 years. The mental health profile of consumers may include:

i. depressive disorders

ii. bipolar disorder

iii. schizophrenia

iv. delusional disorders

v. eating disorders

vi. severe anxiety disorders

vii. delirium

viii. alcohol and drug abuse

ix. complicated suicide risk

b) Consumers may present with a range of challenging behaviours such as shouting, physical aggression, sexual dis-inhibition, undressing and/or intrusive behaviours, wandering, repetitive noisy behaviours, intentional self-harm and withdrawn behaviour.

c) The profile of functional disorders (e.g. schizophrenia) and organic disorders (e.g. dementia), which may be managed within the inpatient unit, require different treatments, a range of therapeutic responses, and different skill sets among health care workers.

d) The primary functions of the IPU include:

i. specialised and comprehensive assessments

ii. clinical review and planning

iii. management of acute risk

iv. treatment focused on clinical symptom reduction with a reasonable expectation of improvement in the short term

v. education and advocacy in mental health services

vi. advice and support for carers and/or whānau

vii. liaison with other services to support transfer of care from the unit to the community as soon as it is clinically safe for the consumer.

e) Therapies provided may include psychotherapy, behavioural therapy and other psychosocial interventions. This may involve reflective therapy, relaxation training and desensitisation for anxiety related disorders.

4.2.3 Workspace

a) Contemporary workspace environments will be provided for MHAS teams including:

i. Administrative

ii. Nursing

iii. Medical

iv. Allied Health

i. Crisis response

ii. Case Management

iii. Adult Community Mental Health

iv. iCAMHS

v. Alcohol and Other Drug (AOD) Service

vi. Maori Mental Health

vii. Students

5. Model of care

5.1 Overview

a) The MHAS model of care aims to support people to participate in their lives as optimally as they can within the constants of their health and disability challenges. For most people staying well is straightforward, while for others it is a far greater challenge, needing significant intervention and support from a range of health professionals and services. While these people may require a varying range of inputs to respond to their needs when unwell, their aim remains the same as everyone else, to stay well and maintain the best possible level of wellness they can.

b) The MHAS model of care adopts a recovery approach which recognises the need to attend to development of hope, secure sense of self, supportive relationships, empowerment, social inclusion, coping skills and meaning in addition to treating acute symptoms.

c) The model of care includes two main elements – planned integrated mental health care and specialist mental health services.[2]

5.2 Consumer Journey Principles

5.2.1 Primary and Community Services

a) Planned integrated community mental health care will be provided from locality bases (including Greymouth Mental Health Facility) with a focus on enhancing self-care, access to brief talking therapies, and integration with primary and community health, PHO mental health services and NGOs.

b) A stepped care model will work in partnership with primary and community/NGO organisations to deliver most services in the community, close to where people live.

c) MHAS will provide early and responsive care to people with acute needs and ongoing support to primary and community services so crises are avoided and the system becomes proactive rather than reactive.

5.2.2 Inpatient Services

a) Points of referrals from across the WCDHB region to the MHAS Inpatient Unit include:

i. nurse practitioners

i. general practitioners

ii. community psychiatric team

iii. crisis response team

iv. internal referrals from other inpatient services

v. internal referrals from outpatient services

vi. Needs Assessment and Service Coordination (NASC) service.

b) At the conclusion of an episode of care, the consumer pathway may include:

i. discharge to home

ii. transfer to another facility

[2] 2014. WCDHB MHAS Model of Care.

iii. transfer to a higher level of care.

c) Hospital admission is needed for people with psychiatric and behavioural problems that cannot be managed in any other setting, with close links to physical health care services.

d) Consumers may be admitted on both a voluntary or involuntary basis.

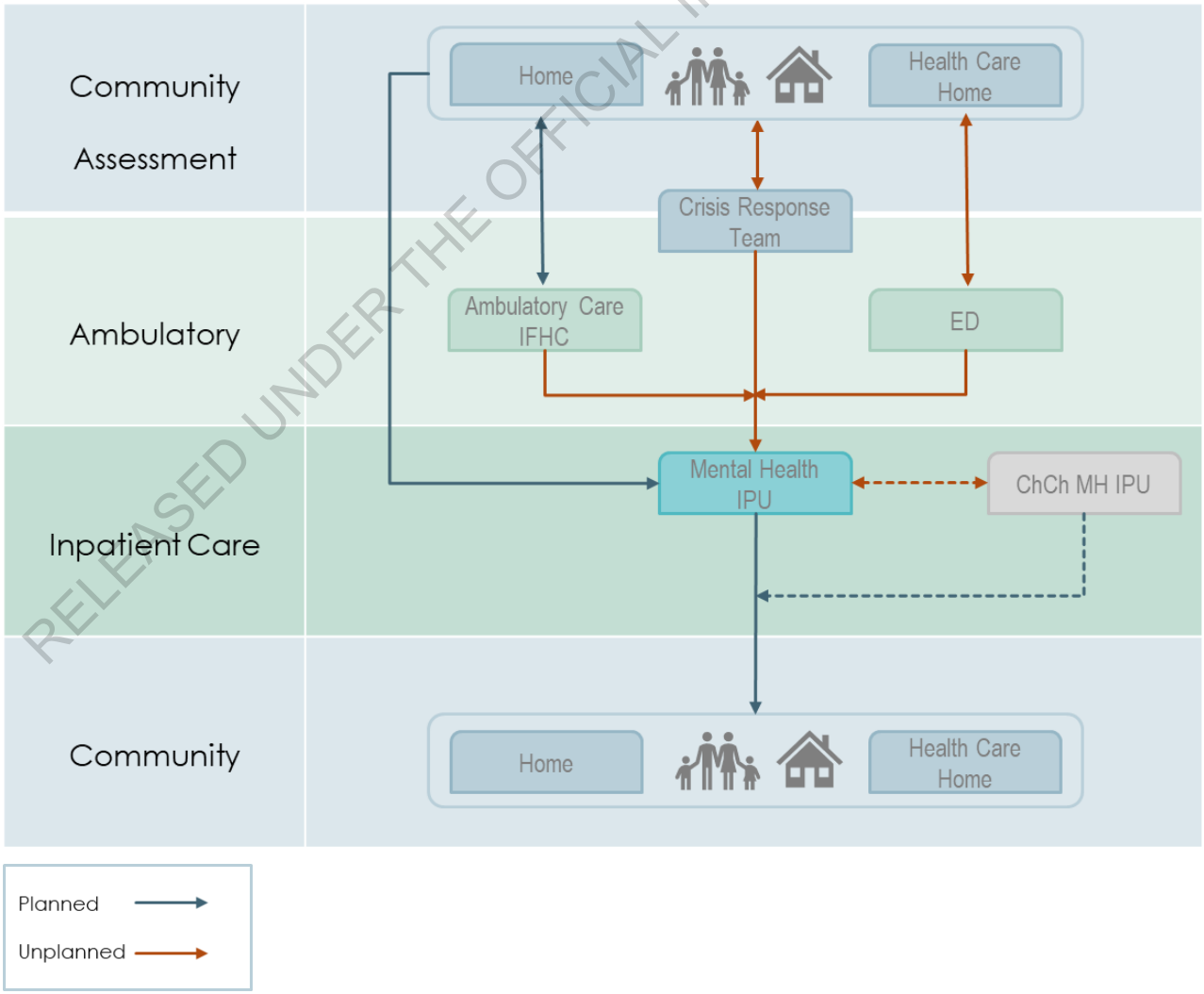
e) Inpatient services will be available for those who need this level of intervention, but the focus will be on getting people back into their own community as quickly as possible with the necessary supports from primary and community services to prevent readmission.

f) To ensure consumers' smooth transition from one level of care to another, (and back again), primary, secondary and tertiary health care should be bridged through consultation, liaison and advice overseen by a specialist interprofessional team.

g) Consumers requiring specialist care for the treatment of eating disorders or alcohol and other drug dependency, may be referred on to Christchurch mental health inpatient services or other specialist facility.

h) The following figure describes the consumer journey for MHAS Services

Figure 1: MHAS Consumer Journey



6. Operational principles

6.1 Overview

a) Operational principles describe how the facility is proposed to function. The following principles and approaches are indicative only and based on early discussions.

b) The MHAS Inpatient Unit will have a comprehensive operational policy document containing clear policies aimed at acknowledging risks and ensuring the health and safety of all staff and consumers.

6.2 Access

a) The inpatient unit will all operate 24 hours a day every day of the year.

b) Access to the inpatient unit during normal hours should be via a dedicated reception which will have oversight of the unit entry and waiting areas.

c) Access control systems will promote ease of movement around the facility and ensure the safety and security of consumers, visitors and staff. This may include wearable access control solutions for staff.

d) There should be a separate and discreet entry or entries for staff, and goods and supplies operated by controlled access for authorised personnel only.

6.3 Admissions

a) Unplanned admissions will commonly arise from the Emergency Department or IFHC.

b) Physical condition and weather permitting, staff may walk with consumer

c) Assessment of mental and physical health presentations will indicate if consumers may walk from the Grey Base Hospital ED or IFHC to the MHAS Inpatient Unit, or require assistance including police intervention and/or internal vehicle transfer.

d) Transfer from other inpatient units to the Mental Health Inpatient Unit may occur in consultation with the service when the mental health needs of a consumer alter and are determined as requiring specialist care.

6.4 Dignity in risk

a) Passive and active security and access control systems will be utilised to support consumer safety while maintaining dignity in risk

b) People have the right to:

   i. be treated with respect, dignity and empathy without judgement

   ii. be supported to retain as much autonomy as possible

   iii. access the most appropriate services to meet their needs in the least restrictive environments possible.

c) Service providers should regularly review and reassess the care they are providing to ensure consumers are receiving the most appropriate treatment and support.

6.5 Low stimulus environment

a) The inpatient unit accommodation will provide low stimulus rooms and sensory modulation rooms to provide a therapeutic environment to support care and management of consumer. This approach is consistent with Zero Seclusion 2020.

6.6 Medication management

a) Medications will be prescribed and dispensed as required.

b) A secure medication room is required for storage of medications in the inpatient unit and secure entry assessment zone.

c) Progression to the use of automated medication dispensing units should be considered with space allowance to support this transition.

6.7 Medical emergency response

a) Established protocols and policies will guide the provision and resourcing of the medical emergency response team for the Mental Health Facility.

b) A nurse call system and a dedicated bay for resuscitation trolley parking will support emergency response.

6.8 Mental health tribunal

a) Mental health tribunal hearings will occur within the Mental Health Facility on occasion. A multipurpose room will provide dual purpose for mental health tribunal hearings and as a meeting room.

b) The room will be located on the perimeter of the unit with two points of egress.

6.9 Clinical Information

a) Future transition to an electronic health record should be supported with access to networked information terminals at a variety of locations ranging from the bedside, staff hubs, staff offices and wireless devices.

b) Electronic and interactive consumer journey boards or screens may be used to optimise on communication regarding consumer flow and bed accessibility. The boards will be installed within designated clinical areas for consumer flow coordination in a discreet but readily accessible location for staff.

6.10 Cultural safety

a) The services will provide the necessary information and cultural support for consumers, their whānau, and appropriate others to enable them to be active participants in the assessment, treatment and rehabilitation process.

b) The physical environment will promote principles of cultural safety, competency, and be responsive and supportive of the beliefs and practices of Māori.

6.11 Enhanced observation

a) Consumer rooms will be clustered in pods to facilitate staff efficiency, meal relief, back-up staff assistance on routine or emergency basis and optimise consumer supervision particularly at night when staffing levels are lower.

b) The inpatient environment will support observation and protection for those consumers at risk to themselves or others.

c) Good observation throughout the inpatient unit will support early identification and care planning of escalating behaviours.

6.12 Whānau facilities

a) Whānau will be encouraged to participate in care as much as they are willing and able. This will include bedside handover, whānau conferencing and discharge planning.

b) Lockers, beverage bay and public amenities will be available at the main entrance for visitors to store their bags prior to visiting the inpatient unit.

c) A whānau room will be provided.

d) Lounge and dining areas will support inclusion of carers and whānau in care and activities.

6.13 Non-Clinical support services

a) All support for the stand-alone inpatient unit including food services, supply and environment services will be provided from services based within the Grey Base Hospital.

b) A separate point of access into the Mental Health unit will be provided as a service entry.

6.14 Privacy

a) The design will establish a hierarchy of zoning and access which promotes visual and acoustic privacy.

b) Promote the maintenance of privacy of consumer information, with ease of access to quiet rooms for confidential discussions.

c) Privacy is an essential element, including the ability not to be overheard.

d) Collaboration spaces should allow confidential discussions.

6.15 Safety

a) Policies, procedures and regular staff training should be in placed to support the management of challenging behaviours.

b) The Mental Health Facility should provide a safe and secure environment for consumers, staff and visitors while retaining a non-threatening and supportive atmosphere conducive to recovery.

c) Passive and active strategies will support the maintenance of safety and security for consumers.

d) Furniture, fittings and equipment should ensure that users are not exposed to avoidable risks of injury.

e) Fixed staff duress alarms will be located at all staff stations.

f) Staff stations should not be enclosed however the design of the area should provide a path of direct egress into adjoining accommodation that can be locked.

6.16 Workspace

a) Dedicated clinical and administrative resources will be provided within the inpatient unit.

b) Collaborative workspace for community teams will be configured and clustered according to teams.

c) Community team workspace will be provided separate to the clinical area.

   i. Focus rooms will be provided close to workspace to support confidential conversations and a space for concentrated work.

   ii. A breakout area will provide space for informal discussions and reflection.

iii. The allocation of types of workstation should be based on the work roles and activities of the individual and the frequency of these activities. The allocation should involve input from the team leader. Workstations may be either allocated, shared, or hot desk.

d) The mental health tribunal room will provide dual use as a meeting room for staff access.

7. Workforce

7.1 Staffing model

a) Mental Health care across the West Coast will utilise mental health staff with specialised skills to enhance patient care across the spectrum of severity and illness course.

b) Community and inpatient unit care will be provided by an interprofessional team of nurses, psychiatrists, geriatricians, physicians and allied health staff.

c) There should be ongoing development of cultural competencies to enable the workforce to respond to the mental health and addiction needs of minority groups of any age.

d) FTE projections will be in accordance with industrial and professional body agreements.

7.1.1 Inpatient Unit staffing

a) Operational support staff may include orderlies, health care assistants, hotel services and others.

b) Rostered shifts for nursing will provide continuous cover 24 hours a day every day of the year.

c) Administration staff will provide cover seven days a week on an extended hours basis.

7.2 MHAS workforce roles

The future profile of roles representing the MHAS workforce may include:

a) Team managers

b) Mental health nurses

c) Nurse educator

d) Nurse consultants

e) Nurse practitioner

f) Psychiatrists

g) Pharmacists

h) Clinical psychologists

i) Social workers

j) Physiotherapists

k) Occupational therapists

l) Dietetics

m) Māori health kaimahi (worker)

n) Quality Facilitator

o) Needs Assessors

p) Counsellors

q) Support workers

r) Students

s) Administrative support.

8. Innovation

8.1 Models of care

The model of care for Mental Health and Addiction services will be influenced by innovation, and current and future trends emerging in technology, equipment, systems and processes. These may include:

a) Increased capacity and capability for community-based crisis response and acute care management.

b) Increased service continuity and collaboration between inpatient, specialist community and primary care.

c) Increased integration of mental health services with physical health services.

d) Transition to an electronic health record

e) Use of decision support tools and enhanced IT support for consumer and general practitioner communication

f) Improvements to referral and assessment processes supported by centralised coordination of referrals, improvements in scheduling systems, and electronic health records.

8.2 Information and Communication

The following tools used to enhance information management and communication will include but not be limited to the following:

g) video intercom systems to ensure external key entry points are observed so that visitors to the unit can be managed after hours.

h) consumer acuity and workload management tools

i) smart phone portable devices linked to nurse call system

j) nurse call - provision of a call system that allows consumers and staff to alert other staff in a discreet manner at all times.

8.3 Equipment

The following medical equipment may be used to increase efficiency and safety in the delivery of consumer care:

a) wearable access control

b) portable duress alarms

c) profiled automated medication dispensing workstations

d) stock flow type storage systems.

9. External functional relationships

9.1 Interpretation

The external functional relationships are defined by both requisite proximity and the nature of the path of travel between functional planning units or service areas using the following descriptors:

a) Immediate access - meaning side-by-side or directly across an internal corridor.

b) Direct access - linking components by a horizontally or vertically contiguous route.

c) Direct mechanical - linking components by mechanical circulation.

d) Ready access - linking accommodation components by a mix of horizontal and vertical unimpeded routes which do not cross over with public travel routes.

e) Easy access - means accessible via internal and external routes including general public routes.

f) Where an external relationship has not been specifically stated, this should be interpreted as 'easy access'.

9.2 Mental Health Facility key external relationships

a) Immediate access to:
   i. Safe wandering external area

b) Direct access to:
   i. Nil identified

c) Ready access to:
   i. Emergency department
   ii. Crisis response team
   iii. Dedicated workspace for staff

d) Easy access to:
   i. IHFC
   ii. Pharmacy
   iii. Security services
   iv. Non-clinical support services
   v. Dedicated parking for staff
   vi. All other services

10. Internal functional relationships

10.1 Description and function

10.1.1 Internal relationships

Groupings or logical planning zones are clusters of rooms which support the same activity within a unit. Effective planning approaches to grouping rooms can achieve lean, efficient workflows and reduce travel distances for staff.

a) A graphic will portray the desired functional groupings for a particular unit.

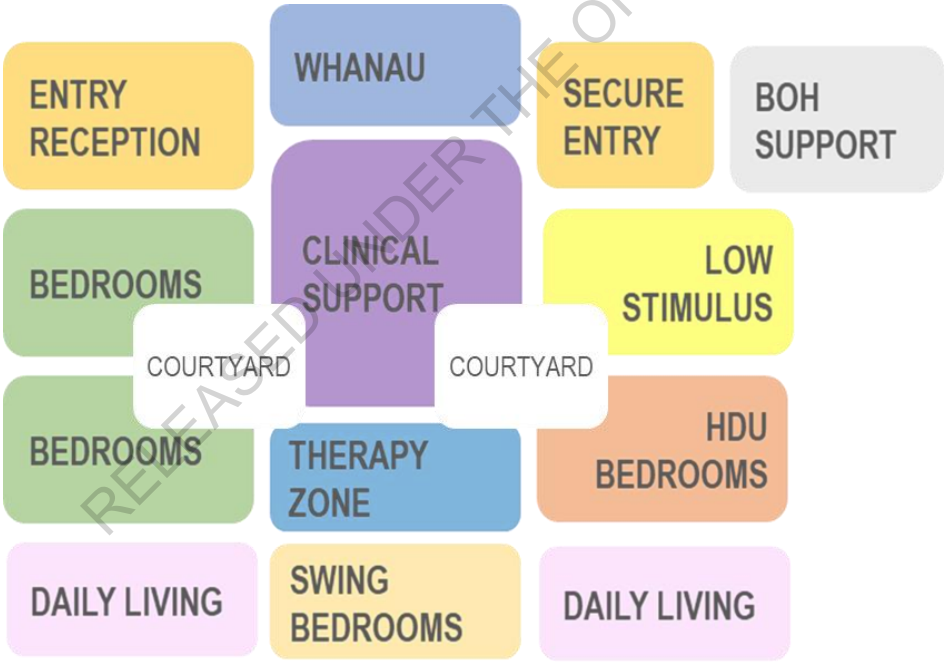
b) The Schedule of Accommodation has been organised in such a way to reflect the synergies and adjacencies of the functional groups and the specific accommodation content.

c) The internal relationships for groups of rooms and individual rooms within a unit will be reflected in in a diagram of shapes and shades which convey a consistent theme throughout the briefing documents.

d) Descriptors for internal relationships will use terms like contiguous, immediately adjacent, adjoining, and direct line of sight.

e) It should be noted that any diagrams contained in the functional design brief is not intended to reflect an actual floor plan nor do the shapes represent scale and proportion.

Figure 2: Mental Health Inpatient Unit internal functional groupings



10.2 Internal functional groupings

10.2.1 Functional groupings

The following describe the internal functional groupings to achieve groupings of rooms which are logical and support efficient work flows for staff within the Mental Health Facility:

a) Front of house

b) Consumer accommodation

c) Daily living zone

d) Therapy zone

e) High needs accommodation

f) High needs daily living zone

g) Clinical support

h) Non-clinical support

i) Staff resources

j) Workspace

11. Specific design principles and requirements

11.1 Design Principles

11.1.1 Consumer focused

a) Supports contemporary models of care centred on the consumer.

b) As an acute mental health unit, the provision of a supportive and therapeutic environment for both physical and psychological health complaints will require a balanced design response. The inclusion of medical gases and other fitments essential to support acute care will require a modification to ensure that mental health compliance is maintained.

c) The facility should be compliant with all guideline recommendations for mental health services including anti-ligature. The perimeter of the building will be responsive to crime prevention through environmental design (CPED).

d) The provision of single rooms will support the separation of vulnerable cohorts.

e) Promote the maintenance of privacy of consumer information, with ease of access to quiet rooms for confidential discussions with both consumer and whānau.

f) The environment should encourage independence, activity and participation with a choice of day areas.

g) Provide a good level of visibility between staff and consumers, while maintaining a level of visual and acoustic privacy.

h) Suitable flexible and adaptable environments will support various in unit therapies and psychosocial interventions including daily living assessments, relaxation, cognitive stimulation, individual and group work, organised games, music, walking groups or breakfast clubs.

i) Provision of dining facilities, at a domestic scale, supports a consumer care focussed model and provides for separation of vulnerable cohorts at meal times if required. The dining facilities shall also support in unit activities of daily living (ADL) assessment activities.

11.1.2 Whānaungatanga

a) Promotes whānau and community support structures.

b) Engagement with whānau and other support persons is a core component of care. Access by support persons will be encouraged.

c) The service will provide spaces for whānau and support cultural traditions, protocols and customs.

11.1.3 Mana whenua

a) Design should recognise and reflect local culture, heritage, and Te Ao Māori.

b) The design will provide ease of access to outdoor spaces and a culturally acceptable approach into the building's main entry point.

c) The facility design will create environments which supports whānau, community, and spiritual connectivity, recognising the importance of place, people and ancestry.

d) There are opportunities for the design to integrate local and Māori artwork or design cues to connect with community. This detail will be explored in further design phases.

11.1.4 Manaakitanga

a) Promotes a caring, welcoming and positive experience.

b) The provision of a private and confidential environment is an essential element.

11.1.5 Kaitiakitanga

a) Promotes sustainability and provides an enduring, future-focused development strategy.

b) Adaptable spaces are required to minimise risk associated with care of consumer presenting with mental health complaints.

c) Flexible workspaces will allow for easy layout changes or expansion and contraction to suit changing needs, varying tasks and different personal needs.

d) Environmentally sustainable design initiatives are employed to reduce carbon footprint and satisfy employee and public aspirations to contribute positively to environmentally responsible development.

11.1.6 Flexibility

a) Provides a planning solution to support flexible usage and evolving models of care.

b) Advancements in technology will allow for flexibility in the workspace, allowing for tasks to be carried out in a variety of working environments.

c) The ICT and FF&E (furniture, fixtures, or other equipment) will support progression to a digital environment and increased utilisation of telehealth services.

d) The distribution of inpatient beds and design response should support flexible use to accommodate varying activity between low and high needs cohorts.

11.1.7 Efficient planning

a) Provides safe and functional clinical relationships and flows.

b) Well organised functional planning, including circulation pathways, will promote operational efficiencies and reduce space requirements, lowering operating costs.

c) The planning response will support the productive ward model in all zones from entry | reception though to consumer/whānau care area.

d) Office spaces and staff meeting rooms will not be used for consumer interaction.

e) The non-clinical support services model assumes linen, food, environmental services models will be delivered to the unit from the main hospital building. Separation of public and service flows is required.

11.1.8 Value for money

a) Provides value for money with new investment and supports the timely delivery of a safe and appropriate facility.

b) Flexible workspaces will allow for easy layout changes or expansion and contraction to suit changing needs, varying tasks and different personal needs.

11.1.9 Haumaru

a) Provides physical and psychological safety.

b) An environment which provides a lower level of stimulus to assist self-modulation and de-escalation is required.

c) Provision of a smaller, less clinical environment provides a more therapeutic environment with opportunities to engage in activities of daily living.

d) The design should ensure there are no dangerous materials accessible to consumers, including medications, sharp objects or inappropriate furniture and fittings that may be used for self-harm or harm to another person.

e) To enable appropriate management of both acute or vulnerable consumers, and other challenging or disruptive behaviours, a variety of spaces will be provided including waiting spaces, consumer lounge, and access to outdoor areas.

f) Responsible materials selection will contribute to improved health outcomes with the specification of less volatile and more environmentally sustainable systems and materials.

11.1.10 Ahurutanga

a) Provides a warm and comforting environment that promotes wellbeing and positive therapeutic results.

b) Layouts will provide better access to natural light and ventilation, assisting with consumer orientation, and improving health outcomes for consumers and staff.

c) A range of therapy spaces which provide for flexibility of use with the ability to respond to acute consumer needs.

d) The management of acoustics is an important consideration as a calm and therapeutic environment is needed.

e) Inpatient areas to provide opportunities for exercise within the recreational and/or therapy spaces.

f) Access to outdoor areas may further enhance the delivery of therapeutic care.

11.2 Specific Design requirements

11.2.1 Front of House

a) Light filled entrances and waiting spaces should provide a welcoming and inclusive environment.

b) A reception will be positioned to observe entry to the unit and waiting space. It will provide for clerical admission services and shall support a transition to electronic records management.

c) Passive and active measures will be applied to manage the security and access control requirements for the unit in support of the needs of the consumer cohort.

d) The reception area should be safe for staff with two points of egress including direct access to a safe retreat in an adjacent secure area. A fixed duress alarm should be provided in this zone.

e) An interview room for supporting consumers upon admission should be provided either in close proximity to the public entry or directly from the waiting space. This room may also be used for other purposes such as meetings with support workers, whānau and carers.

f) Access to general amenities for consumers, whānau and visitors will be provided in this area.

g) A tribunal room will be used to conduct hearings, undertake confidential discussions between staff, consumers and supporting members and representatives where required.

   i. Teleconferencing and videoconference facilities will be required in this room.

   ii. A mental health interview room should be located in close proximity to the tribunal room for private discussions such as with legal representatives.

h) The tribunal room and all interview rooms require two points of safe access and egress.

11.2.2 Consumer accommodation

a) The unit will be clustered in pods of single rooms to enable separation of cohorts. A dedicated ensuite will be provided to all bed rooms.

b) An external view of nature and access to natural light will assist with orientation and contribute to the provision of a homely environment.

c) Consumers should be able to lock their door with a privacy lock. Staff will be able to override locks if necessary.

11.2.3 Daily living zone

a) A dining room will provide a defined space for consumers to eat at tables, seated in small groups or individually.

b) Kitchen facilities with ability to secure cupboards and drawers is required to support activities of daily living and functional assessments. Kitchen fixed electrical appliances such as microwave or oven should have a master control function for staff which is separate to the kitchen environment to provide ability to restrict appliance function at times for consumer safety.

c) Décor should reflect a domestic environment.

d) The lounge should open onto an outdoor area and should be observable by staff.

e) There should be a selection of comfortable but durable furniture that can be configured for a range of activities.

f) Courtyards are integral and are essential to consumer treatment and well-being. Careful consideration is required for safety and all weather access including shaded and/or covered areas. All outdoor areas need to be secure.

11.2.4 Therapy zone

a) Dedicated consumer spaces will be provided to support programmes of activities and therapies.

b) Provision for securable storage of materials and equipment for use in occupational therapies should be provided immediately adjacent to the therapy areas. This may be a dedicated room or a cupboard within the therapy space is also appropriate.

c) Access to a wet area for occupational therapy and recreational activities is required.

d) Access to natural light and ventilation is desirable.

11.2.5 High needs accommodation

a) This zone should be capable of secure separation from the general zone, but able to be used as an unlocked facility at other times depending on clinical need.

b) The layout should facilitate the controlled movement of staff and consumers between zones.

c) An assessment zone with interview room will be accessible via a secure external entry.

11.2.6 High needs daily living zone

a) Dedicated lounge/dining facilities with access to a secure outdoor courtyard.

b) This zone will have access to a multi-function activity area, and potentially dual access to therapy resources in the low needs zones.

c) A sensory modulation space to promote recovery and rehabilitation, where consumers have the opportunity to manage distress and agitation using sensory modulation equipment.

11.2.7 Secure Assessment area

a) External entry to the secure assessment area will need to provide a secured yard which can accommodate an emergency vehicle.

b) Access control to this zone is required including interlock function to control egress.

c) The secure assessment zone will provide for an extended period of assessment (4-8 hours) with access to beverage making facilities and ensuite.

d) Clinical support resources including secure medication storage, consumables and PPE should be readily available.

11.2.8 Low stimulus area

a) A low stimulus area will support self regulation and de-escalation consistent with non seclusion policies.

b) The area will provide a calming space for consumers with the ability to move between a bed area, retreat and outside space.

c) This area requires safe access and egress, soft furnishings, and the ability to play music.

d) Ease of movement from both the high dependency and low needs unit is required.

e) Direct visualization by staff is required.

f) This zone may be used as consumer accommodation in times of peak activity, with alternative support spaces utlised for consumer self-regulation and de-escalation requirements.

11.2.9 Clinical Support

a) Clinical support resources will include a medication room, treatment room, store, dirty utility/disposal room, a linen bay and a resuscitation trolley bay.

b) The treatment room should provide access from both inpatient and front of house zones.

c) Access to the medication room should be staff only via a proximity card reader.

d) A staff base will provide an open space with immediate access and visual connection to inpatient consumer zones.

e) The clinical workroom should be adjacent to the staff base and provide for confidential staff handovers and documentation requirements.

f) An office for the inpatient unit manager should provide access to inpatient and front of house zones.

11.2.10 Staff resources

a) Staff resources will include staff rest area, staff property store, and staff amenities.

b) It is assumed that these resources will be located in a staff-only zone.

c) Teleconferencing and videoconference facilities will be required in all meeting rooms.

11.2.11 Workspace

a) Workspace should provide flows to the front of house and staff resource zones that are separate to the inpatient unit flows to prevent use of the inpatient unit as a thoroughfare.

b) Contemporary workspaces will be provided for each team with a combination of allocated and shared workstations.

c) Administration staff workstations should provide sound attenuation to enable dictation requirements.

d) Secure storage facility is required for administration records.

e) Shared zones will provide the following:

   i. Team Leader office

   ii. Hot desks

   iii. Breakout space

   iv. Photocopy and Stationery store area

   v. Focus rooms which may be distributed within the workspace zone to provide for all community teams.

12. Schedule of Accommodation

Functional Zone	Room Code	Room Name	Room No.	NDA m2	Area Commentary
Grey Base Hospital					
Mental Health Facility					
Front of House			30%	179	
Entry | Reception | Waiting				103	
Entry | Reception	AIRLE-10	Airlock	1	10	
Entry | Reception	REC-15	Reception/ Clerical	1	9	Admin - Receptionist
Entry | Reception	ST-GEN	Meeting Room	1	24	Used initially as file room then transition to meeting room
Entry | Reception	WAIT-10	Whanau / Patient Waiting	1	9	
Entry | Reception	WCAC-I	Toilet - Accessible	1	6	
Entry | Reception	WCPU-3	Toilet - Public	2	6	
Entry | Reception	INTF	Interview Room	1	14	
Whanau				26	
Whanau	MEET-20	Whanau Room	1	18	Access to external area
Whanau	BBEV-OP	Bay - Beverage	1	2	Incl in whanau room
MH Tribunal				50	
MH Tribunal	MEET-L-20	Meeting Room	1	40	Multipurpose - To support staff mtg requirements
Client Accommodation				186	2.3
Accomm. Gen. A		4 Bed pod		121	
Accomm. Gen. A	1BR-MH	1 Bed Room - Mental Health	1	17	
Accomm. Gen. A	ENS-MH	Ensuite - Mental Health	1	5	
Accomm. Gen. A	1BR-MH	1 Bed Room - Mental Health	1	17	
Accomm. Gen. A	ENS-MH	Ensuite - Mental Health	1	5	
Accomm. Gen. A	1BR-MH	1 Bed Room - Mental Health	1	17	
Accomm. Gen. A	ENS-MH	Ensuite - Mental Health	1	5	
Accomm. Gen. A	1BR-MH	1 Bed Room - Mental Health	1	17	
Accomm. Gen. A	ENS-MH	Ensuite - Mental Health	1	5	
Accomm. Gen. A		Break out zone	1	6	
Accomm. Special A		Two Bed pod		65	
Accomm. Special A	1BR-MH	1 Bed Room - Mental Health	1	17	
Accomm. Special A	ENS-MH	Ensuite - Mental Health	1	5	
Accomm. Special A	1BR-MH	1 Bed Room - Mental Health	1	17	
Accomm. Special A	ENS-MH	Ensuite - Mental Health	1	5	
Accomm. Special A		Break out zone	1	6	
Accomm. Special A		External - Courtyard	1		Based on 7.5 m2 per person
Daily living zone				108	1.3
Dining & lounge				108	7.5sqm/person - dining/lounge/media
Dining & lounge	INTF	Interview Room	1	14	
Dining & lounge	DINR	Dining - Patients	1	30	space distributed between main dining and kitchenette areas
Dining & lounge	BBEV	Bay - Beverage	1	8	Area incorporated into kitchenette

Dining & lounge	LNPT-10	Lounge - Patient Family	1	18	
Dining & lounge		Media Room	1	12	TV / Music
Therapy zone				**69**	**0.8**
Therapy zone				**69**	
Therapy zone		Multi-function activity area	1	20	
Therapy zone		Occupational Therapy Room	1	15	
Therapy zone	STGN-9	Store - General	1	9	
Therapy zone	LAUND-MH	Laundry - Mental Health	1	8	May be used for ADL
Therapy zone		External - Courtyard	1		Based on AHFG 7.5 m2 per person. Minimum 20sqm area.
High Needs Accommodation			**2**	**127**	**1.5**
Assessment Zone				**30**	
Assessment Zone	INTF	Interview Room	1	14	
Assessment Zone	WCPT	Toilet - patient	1	3	
Assessment Zone		Bay - Beverage	1	2	
Secure zone	STDR-10	Medication Room	1	2	recessed secure bay
Secure zone	STGN-9	Store - General	1	2	recessed secure bay
Secure zone		Low stimulus - not in bed count		**40**	
Secure zone	1BR-MH	1 Bed Room - Low Stimulus MH	1	15	not in bed count
Secure zone	ENS-MH	Ensuite - LS MH	1	5	
Secure zone		Retreat - Low Stimulus	1	10	
Secure zone		External - Courtyard	1		Based on AHFG 10 m2 per person - 1 bed
Accomm. Special B		Two Bed pod		**57**	
Accomm. Special B	1BR-MH	1 Bed Room - Mental Health	1	17	
Accomm. Special B	ENS-MH	Ensuite - Mental Health	1	5	
Accomm. Special B	1BR-MH	1 Bed Room - Mental Health	1	17	
Accomm. Special B	ENS-MH	Ensuite - Mental Health	1	5	
High Needs - Daily living zone				**53**	**0.7**
Activity zone				**53**	10sqm/person - dining/lounge/activity
Activity zone		Bay - Beverage	1	4	
Activity zone	DINR	Sub-Dining - Patients	1	9	To support special need or vulnerable patient cohort
Activity zone	LNPT-10	Lounge - Patient Family	1	15	Includes activities
Activity zone		Sensory Modulation	1	12	
Activity zone		External - Courtyard	1		Based on AHFG 10 m2 per person - 2 beds
Clinical Support				**109**	**1.3**
Clincial support	Shared			**59**	
Clincial support	STDR-10	Medication Room	1	10	Shared between IPU and HDU
Clincial support	STGN-9	Store - Consumables	1	6	May be open bay
Clincial support	BLIN	Bay - Linen	1	2	
Clincial support	TRMT	Treatment Room	1	14	
Clincial support	DTUR-10	Dirty Utility / Disposal	1	10	Shared between IPU and HDU
Clincial support	STPP	Store - Patient property	1	2	
Clincial support	BRES	Bay - Resuscitation Trolley	1	1	Central location
Staff Support	Shared			**50**	
Staff Support	SSTN-14	Staff Base	1	9	

Staff Support	OFF-CL2	Office - Clinical Workroom	1	15	Open zone for handover etc
Staff Support	OFF-S9	Office - Single person	1	9	CNM
Staff Support	STPP	Bay - Handwash, Type B	1	1	
Staff Support	WCST	Toilet - Staff	2	6	
Non Clinical Support				**16**	**0.2**
Non Clinical				**16**	
Non Clinical	CLRM-5	Cleaner's Room	1	5	
Non Clinical		Holding Room	1	8	To support logistic flows from main building
Staff Resources				**37**	**0.5**
Staff Amenities				**37**	
Staff Amenities	SRM-15	Staff Room	1	20	
Staff Amenities	PROP-2	Store - Staff property	1	2	
Staff Amenities	WCST	Toilet - Staff	2	6	
Staff Amenities	SHWR	Shower - Staff	1	3	
Workspace				**289**	
Administrative				**289**	
Workspace	OFF-WS	Allocated Workstation, 5.5m2	3	17	
Shared zone					
Workspace	OFF-S9	Office - Single person	1	9	Team Leader
Workspace	OFF-WS	Allocated Workstation, 5.5m2	3	17	Educator | Quality Facilitator | Allied Health
Workspace		Hot Desk	4	9	Hot desks to support all community teams. Ratio of 1:6
Workspace	STPS-8	Store - Photocopy/ Stationery	1	8	
Workspace		Breakout space	1	9	
Workspace	INTF	Focus Room	4	24	
Adult Community Service					
Workspace	OFF-WS	Allocated Workstation, 5.5m2	2	11	
Workspace	OFF-WS	Shared Workstation, 5.5m2	3	17	1:2
Crisis Response/Case Mgt team					
Workspace	OFF-WS	Allocated Workstation, 5.5m2	6	33	
Workspace	OFF-WS	Shared Workstation, 5.5m2	3	17	1:2
Medical team					
Workspace	OFF-WS	Allocated Workstation, 5.5m2	2	11	Registrar & Psychiatrist
Workspace	OFF-WS	Shared Workstation, 5.5m2	2	11	2 psychiatrists present at one time
AOD team					
Workspace	OFF-WS	Allocated Workstation, 5.5m2	1	6	
Workspace	OFF-WS	Shared Workstation, 5.5m2	2	11	1:2
CAMHS					
Workspace	OFF-WS	Allocated Workstation, 5.5m2	1	6	
Workspace	OFF-WS	Shared Workstation, 5.5m2	2	11	1:2
Maori MH Team					
Workspace	OFF-WS	Allocated Workstation, 5.5m2	3	17	

[redacted]

Replacement of the Mental Health Facility at Grey Base Hospital

Single stage business case version 1.3

Prepared by Sapere on behalf of West Coast District Health Board
FINAL DRAFT 22 June 2020

Document control

Document name	Replacement of the Mental Health Facility at Grey Base Hospital
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0.1		Draft strategic, commercial, management cases for feedback
1.0	5 June 2020	Working draft for executive and service input
1.1	11 June 2020	Updated post-executive team workshop Financial case for CFO review & sign-off
1.2	17 June 2020	Economic case updated
1.3	22 June 2020	Final draft for Board

Document review

Group/Role	Name	Review status
Project Director	Mark Newsome	Reviewed
Executive Team & Canterbury DHB mental health leadership		Reviewed

Document approvals

Group/Role	Name	Sign-off function	Complete
Executive Team			
Board			

Contents

Appendices

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Glossary

Abbreviation	Stands for
AOD	Alcohol and Other Drug
(A)LOS	(Average) Length of Stay
CDHB	Canterbury District Health Board
CSF	Critical success factor
DHB	District Health Board
ED	Emergency Department
FTE	Full-time equivalent
GETS	Government Electronic Tender Service
GFA	Gross Floor Area
HoNOS	Health of the Nation Outcome Scale
HVAC	Heating, Ventilation and Air Conditioning
ICAMHS	Infant, Child and Adolescent Mental Health Service
IFHC	Integrated Family Health Centre
ILM	Investment Logic Mapping
LSF	Living Standards Framework
MBIE	Ministry of Business, Innovation and Employment
MHAS	Mental Health and Addictions Service
NAMP	National Asset Management Plan
NGO	Non-Government Organisation
NPV	Net Present Value
PCG	Project Control Group
PHO	Primary Health Organisations
QS	Quantity Surveyor
RfP	Request for Proposal
RLB	Rider Levett Bucknall
WCDHB	West Coast District Health Board

Executive summary

West Coast District Health Board (WCDHB) seeks approval to invest 9(2)(b)(ii), 9(2) between 2020/21 and 2022/23 to replace the mental health and addictions facility on the Grey Base Hospital campus.

Strategic case

The Manaakitanga unit at Grey Base Hospital in Greymouth co-locates inpatient and outpatient activity with the broader Mental Health team workspace located alongside. Manaakitanga has a nine bed acute inpatient unit. WCDHB has historically had a high inpatient admission rate, likely to be the result of a range of factors including rurality, access to crisis services, risk profiles, concerns about suicide rate, and access to alternatives to inpatient care. Average occupancy in the inpatient ward has gradually reduced, but there can be spikes exceeding the available bed capacity (the current nine bed capacity has not been exceeded since early 2019).

Moving towards an integrated approach between mental health and physical health services

A stepped care model is being developed that involves the WCDHB service working in partnership with primary and community/Non-Government Organisations (NGOs) to deliver most services in the community, close to where people live. The proposed model of care includes two main elements – planned integrated mental health care and specialist mental health services.

Planned integrated community mental health care could be provided from locality bases. Acute response would follow the same pattern as an acute response to physical health—one where the local service works to the scope and skill level available and, if required, stabilises ready for transport/transfer to the specialist service. More locally responsive acute services (crisis assessment and treatment, respite options) are being developed.

The WCDHB Mental Health and Addictions Service (MHAS) will continue to provide specialist clinical services. Inpatient services will be available for those who need this level of intensity but the focus will be on getting people back into their own community as quickly as possible with the necessary supports from primary and community services to prevent readmission. The need for inpatient beds is expected to reduce over time as viable alternatives are developed in the community such as assertive home-based treatment service.

The problem definition is clustered under three headings

An Investment Logic Mapping (ILM) workshop was held with key stakeholders on 8 April 2020. The stakeholder group considered the causes and consequences of the key problems. Three problem groupings were identified:

1. Ignores basic rules of a safe and therapeutic environment for consumers and staff
2. Doesn't support positive consumer experience, respect for whānau, and tikanga Māori
3. Doesn't provide connectivity, flexibility and responsiveness that enhances service resilience and integration

The Strategic Case describes how these problems play out in service delivery, including injuries, assaults/threats and missing persons, limited safe access to the unit, a lack of privacy, undersized bedrooms, a high care area described as sterile and general deterioration of the building throughout. Accommodation is not reflective of the consumer journey or adaptable to different levels of acuity. With the demolition of the existing hospital building the Manaakitanga unit will be dislocated from other services in the main hospital and Integrated Family Health Centre (IFHC). This dislocation will put staff and consumers at risk with emergency response to critical incidents having to come from the other end of the campus.

Investment objectives seek to directly address the key problems

In response to the problems identified, key stakeholders and external consultants developed and circulated a set of investment objectives that seek to directly address the issues.

Objective 1: Fit for purpose, modern and therapeutic environment that is safe for consumers and staff	
Existing arrangements	The desired, contemporary model of care cannot effectively be implemented in the current facility. The unit is over 40 years old, tired, and converted from an old maternity wing. The building's structure, layout and physical environment is not fit for clinical purpose. Outdoor and activity spaces are inadequate for a modern therapeutic environment. Consumer feedback reflects the sterile nature of the high care area. The layout of the unit compromises consumer and staff safety as evidenced by incidents reported in the small unit.
Business needs	A facility that provides safe and functional clinical relationships; and supports contemporary, patient-centred models of care. Provides physical and psychological safety. Provides a warm and comforting environment that promotes wellness and positive therapeutic outcomes.

Objective 2: Positive consumer experience by a facility that demonstrates respect for whānau and embeds tikanga Māori	
Existing arrangements	Consumer experience is negatively impacted from the entry to the facility through to the low stimulus area. There is a lack of privacy and dignity for consumers and whānau, including overlooking of arrivals by other areas and events on the ward occurring in very public ways due to adjacencies within the unit. The current unit does not reflect tikanga Māori, and inadequate facilities limit the ability of whānau to support the consumer journey.
Business needs	A unit that is welcoming and home-like, with an appropriate level of privacy to maintain the dignity of consumers and whānau. Opportunities for whānau involvement in consumers' recovery journey are available in suitable facilities. Recognises local culture, heritage and Te Ao Māori.

Objective 3: Flexible, connected and responsive service that is more resilient and integrated	
Existing arrangements	Accommodation is not reflective of the consumer journey or adaptable to different levels of acuity. There is no ability to cohort people according to their particular needs and the high care area is severely limited. The unit will be left at the opposite end of the campus from the new Te Nikau building when the old hospital is decommissioned/demolished, reducing support from and integration with wider hospital services. The building itself is deteriorating and does not meet current guidelines (e.g. service entry or bedroom sizes).
Business needs	Promotes sustainability and provides a flexible, future-focussed development strategy. Physical environment is flexible and can adapt over time in response to changes in practice and treatment. Ability to cohort people according to acuity, vulnerability, demographic or other needs. Promotes integration of inpatient services with community services, and mental health services with physical services.

Economic case

The options for delivering acute inpatient mental health and addictions services in the smallest (population) and most rural DHB in the country are genuinely limited. The WCDHB Mental Health and Addictions Review and Model of Care determined that short-term acute inpatient services would be available on the West Coast, therefore an option to provide all inpatient services out of Canterbury was discussed, but not formally included on the 'long list'.

A limited number of genuine options for the facility

A User Group was established to work with the business case team and appraise the list of potential options for the mental health facility. 9(2)(j) [redacted] A 'status quo' option is included as the base case.

9(2)(j) [redacted]. Each option has eight beds plus a low stimulus area.

An option had to meet, or partially meet, each investment objective and identified critical success factor to be shortlisted. 9(2)(j) [redacted]

Refurbishment 9(2)(j) [redacted]

A staged refurbishment (of most areas of the building) would involve significant disruption to the service over an extended period of time. Quantity surveyors Rider Levett Bucknall estimated the cost of the refurbishment option at 9(2)(b)(ii), 9(2) [redacted].

The refurbishment achieves a number of improvements compared to the existing facility, for example, all new single bedrooms with ensuites, sea views and immediate access to recreational and activity spaces. However, working within the constraints of the existing building leads to a number of compromises and residual security issues.

9(2)(j) [redacted]

9(2)(j) [redacted]

9(2)(j)

Commercial case

The ongoing impact of COVID-19 on the construction sector is uncertain, and the unique nature of West Coast operations combined with recent construction experience at Grey Base Hospital could see lower competitive pressure on the tender. The scale of this project is smaller than that of the Grey Base Hospital and Health Centre, and therefore may not require a Tier 1 builder, reducing the chances of repeating the challenges seen in that project. Direct market engagement has not occurred, although it is believed some local firms would have the capacity and capability to undertake the project. Some trades are likely to be supplied locally whereas others (e.g. mechanical and electrical) may require Christchurch based firms to deliver the requirements.

A clear preference for a construct only contracting approach

A range of contracting mechanisms have been considered however construct only and design and construct are the two most appropriate contractual structures. WCDHB has a clear preference for a design then construct process. The relatively simple nature of the construction project increases the advantages of a construct only process. Previous experience at Grey Base Hospital and Akaroa Health Centre in Canterbury DHB suggests cost risk is of primary concern. This is best alleviated by providing construction contractors with a fully scheduled and documented design on which to base their tender submission.

WCDHB will procure an architecture firm to progress the design of the mental health facility though to detailed design. The detailed design will define all building elements, materials and systems. Detailed design will feed into both the consenting, and procurement of the construction contractor.

One-step competitive tenders with a cross-functional evaluation team

Both the design and construction contracts will be procured in an open Request for Proposal process via the Government Electronic Tender Service. It is recommended that it is a one-step competitive tender is carried out for both the design and the construction.

An appropriately qualified team will be involved in evaluating bids and recommending the preferred supplier. People with specific knowledge of construction projects and expertise in undertaking evaluations on the scale and nature of projects similar to the facility build will be included on the panel. Care will be taken to ensure there is a diverse mix of members from different backgrounds to enable a broad suite of views are covered.

Evaluation panel membership would consist of the following members: DHB project lead, MHAS clinical representative, Programme Director Construction and Property, WCDHB Facilities Team, WCDHB General Manager, project quantity surveyor. There will also be a set of non-voting specialist advisors (legal, financial, probity, architect).

The design tender evaluation will be conducted by this team with equal weighting applied to price, methodology, experience and capacity criteria. The construction tender evaluation will use a weighted attribute model against the following criteria: price [redacted], methodology [redacted], experience [redacted], capacity [redacted]

WCDHB will seek a risk allocation that fairly and transparently allocates project risks between the construction industry and the DHB.

Financial case

WCDHB recorded deficits between 2015/16 and 2018/19. The DHB has limited reserves with negative working capital of 9(2)(b)(ii) [redacted] at 30 June 2019. There are no investment assets. Starting from 2019/20 WCDHB will require deficit support funding to cover a negative free cash flow position, as cash reserves will have been used up.

This proposal requires capital spending of 9(2)(b)(ii) [redacted] in 2022/23 (nominal dollars). Asset related costs (being depreciation and capital charge) of 9(2)(b)(ii) [redacted] will be incurred for the 10-year period from 2020/21 to 2029/30. The additional annual charge to the statement of comprehensive revenue and expense will be 9(2)(b)(ii) [redacted] in asset related costs. We note that additional revenue of 9(2)(b)(ii) [redacted] in the form of capital charge relief will be provided, which will reduce the net impact on the DHB's position. This net amount of 9(2)(b)(ii) [redacted] represents about [redacted] of DHB expenditure.

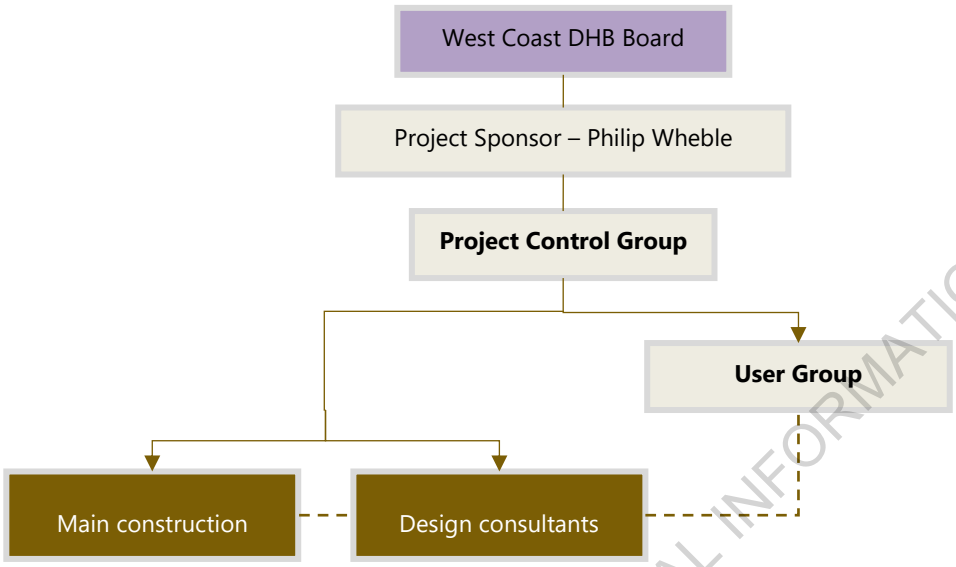
The Ministry of Health has indicated that Crown financing will be available for this project.

Management case

The management case confirms that the proposal is achievable and details the arrangements needed to both ensure successful delivery and to manage project risks, while maintaining a focus on delivery of benefits.

Project arrangements have been developed

The WCDHB Chief Executive has overall responsibility and accountability for the investment. Philip Wheble, General Manager West Coast, is the Project Sponsor. The diagram below shows the project governance and management structure.



An internal governance group will be set up to oversee the project. The Project Control Group leads the development, design and implementation of the work. The existing User Group will be expanded to include a wider range of disciplines and ensure strong nursing input. The group will input into the detailed design of the building. Where required the user group will reach out for input from the community, this may be in form of consultation or secondments onto the group.

Final design decisions will be made by the sponsor in conjunction with the Project Control Group.

Project takes time to develop design

The design and construction programme is not yet confirmed. The next steps following approval of this business case are to:

- confirm the Project Control Group membership
- develop a detailed project management plan for approval by the project control group
- procure detailed design consultants.

The project has four main stages: inception, design (preliminary, developed, detailed), procurement of main contractor, construction. Inception and design is anticipated to run over an approximate 13 month period; contractor procurement to run over an approximate 4 month period and construction to run over an approximate 18 month period.

The project will follow a work programme owned by a Project Director, working closely with the Construction Project Manager. Any changes to the project's capital requirements or risk mitigations will be considered in accordance with the delegated financial authority policy and risk management policy.

Approach to change, risk and benefits management

Recently, an organisation restructure brought the MHAS into the integrated locality health services. To continue on the journey, the culture must develop further, with mental health as part of a joint focus on physical and mental health. WCDHB has undertaken significant change planning during the construction of Grey Base Hospital and the IFHC. This experience will be carried forward into the construction of the mental health unit.

A detailed communications plan will be developed following approval of the business case. The strategic communications advisor will be engaged to develop the plan using their experience of communicating in the trans-alpine community space.

The expected benefits have been initially identified in the Strategic and Economic Cases. Project benefits will be managed during and after the project, with appropriate monitoring and reporting. The Project Sponsor will be responsible for managing the benefits process and will be accountable for the benefit realisation.

A preliminary risk register has been developed including 'high' risks identified at this stage in the project and associated mitigation strategies. A risk schedule for the project will be managed by the Project Director. Ultimate ownership of risks will sit with the Project Sponsor, who will delegate day-to-day management of individual risks to the appropriate person or group. Where applicable, project risks will be escalated as part of the DHB risk management process through the Quality, Finance, Audit and Risk Committee.

WCDHB will commission independent auditors to undertake a set of reviews before, during and after the project—pre-project, mid-project (track performance against budget and timeline), immediate post-project (lessons learned) and post-project (benefits realisation).

1. Introduction

West Coast District Health Board (WCDHB) seeks approval to invest 9(2)(b)(ii), 9(2) between 2020/21 and 2022/23 to replace the mental health facility on the Grey Base Hospital campus.

This business case has been prepared according to the Treasury's Better Business Case guidance and is organised around the five case model:

- Strategic case
- Economic case
- Commercial case
- Financial case
- Management case.

The purpose of this single-stage business case is to:

- confirm the strategic context of the service and how the proposed investment fits within that strategic context; confirm the need to invest and the case for change
- identify a range of potential options and then provide an analysis of the costs, benefits and risks of short-listed options
- prepare the proposal for procurement with a strategy appropriate to the project's scale and location
- plan the funding and management arrangements for successful delivery of the project.

1.1 Manaakitanga mental health facility

Manaakitanga is the mental health facility on the Grey Base Hospital campus in Greymouth. The building was constructed circa 1977/1978 and is a concrete framed building comprising basement, lower ground floor, ground floor and roof plant space.

Figure 1 Manaakitanga mental health unit

The lower ground floor currently houses offices and meeting rooms for allied health. The ground floor houses a nine-bed inpatient unit and offices for mental health staff. The unit was refurbished in 2001, involving partial reuse of facilities built as a maternity wing, and was planned for economic reuse rather than good fit.

1.2 Te Nikau—new Grey Base Hospital and Health Centre

A new hospital building for the Grey Base campus in Greymouth was commissioned by the Ministry of Health, following a detailed business case which outlined the poor condition of existing facilities and their earthquake prone nature, as well as the manifestation of a new model of care for the WCDHB. Many services will be integrated into the new hospital and health centre facility—Te Nikau—which is due to be occupied later in 2020.

Whilst the new building caters for the majority of site activity, several parts of the service were not encompassed as part of the project. The remaining services are on other parts of the site in older existing buildings. The condition of all of these buildings has been assessed separately as part of a National Asset Management Plan (NAMP) undertaken by the Ministry of Health. Following occupation of Te Nikau, the northern portion of the existing hospital is to be demolished and the central portion to be decommissioned. The south end of the building will be temporarily retained with its current Mental Health Service.

1.3 The development of this business case

When the business case for the new hospital and health centre was approved in 2014, the Minister of Health announced there would be further funding for the development of the inpatient mental health facility.[1]

A detailed seismic assessment conducted by Opus International Consultants in 2012 classified the Manaakitanga building as earthquake prone. In 2020, WCDHB engaged WSP (formerly Opus) to establish the seismic performance of the structure in line with the current Ministry of Business Innovation and Employment (MBIE) guidelines.[2] The upgraded assessment found that the building is rated as 55 percent of the New Building Standard when assessed as an Importance Level 3 building.

A site master planning report (the masterplan) was prepared for WCDHB in 2019 to inform a business case for the development of a new mental health facility on the Grey Base Hospital site. The masterplan sought to establish a planning strategy for the commencement of design for a new mental health facility with consideration of the existing site status and the changing status following the commissioning and occupation of the Te Nikau building.

In 2020, WCDHB engaged CCM Architects and Jacobs to provide health planning services and develop options/concepts for the mental health facility, Rider Levett Bucknall (RLB) to provide cost estimation and Sapere to develop the business case. As a result of the national lockdown in response to the threat of COVID-19, the engagement programme was adapted. This meant that meeting and workshop structures shifted from large group sessions in Greymouth to virtual meetings. The attendance and participation at these virtual workshops was very good. The business case team thanks all those involved for managing and contributing during an unprecedented time.

[1] https://www.beehive.govt.nz/release/60-bed-west-coast-hospital-facility-step-closer

[2] The MBIE guidelines and the latest revision of its Chapter C5, 'Yellow Book' (November 2018) provides the current understanding of seismic assessments of existing concrete buildings and precast floor systems.

2. Strategic case: making the case for change

The strategic case outlines the strategic context for the proposal, defines the problem and investment objectives, describes the existing arrangements and business needs; and expected benefits of the investment.

2.1 A unique strategic context

The strategic context considers:

- the organisation and unique population and geographic area it serves
- utilisation of specialist mental health and addiction services
- the strategic direction and model of care WCDHB is working towards.

2.1.1 About the West Coast DHB

WCDHB in collaboration with Canterbury District Health Board (CDHB) is responsible for most publicly funded health services on the West Coast. WCDHB has a statutory responsibility for improving, promoting, and protecting the health of the population living in the region. This includes planning, funding, and providing or contracting services to meet the health needs of the population. In 2019/20, WCDHB received approximately 9(2)(b)(ii) to meet the needs of its population.

Since 2010, WCDHB has shared executive and clinical services with the CDHB. This includes a joint Chief Executive and clinical directors, as well as shared public health and corporate service teams.

The most rural health system in New Zealand

The WCDHB serves a population of 32,600 people[3]. While this number makes WCDHB the smallest District Health Board (DHB) in New Zealand, it has the challenge of covering the third largest geographical area of any DHB, spanning a narrow strip of rugged coastline from Karamea in the North to Haast in the South—the same driving distance as Auckland to Palmerston North. WCDHB is the most sparsely populated DHB in the country with only 1.4 people per square kilometre.[4] This means consumers and health professionals often have to travel long distances to access or deliver services.

WCDHB owns and operates four major health facilities in Westport, Reefton, Greymouth and Hokitika and eight smaller clinics in its more remote areas. Unlike most other DHBs, WCDHB owns and operates four of the seven general practices on the Coast and also operates a district nursing and home-based support service. This makes the DHB a major local employer, with more than 1,000 people directly employed by the WCDHB.[5]

[3] Population projections produced by Stats NZ according to assumptions agreed to by the Ministry of Health (2019).
[4] West Coast DHB Annual Plan 2019/20
[5] Ibid.

In addition, WCDHB holds more than 80 service contracts with other organisations and individuals who provide health and disability services to its population, including pharmacies, lead maternity carers, aged residential care providers, public health and Māori health providers and the West Coast Primary Health Organisation (PHO).

A formal transalpine service partnership established with the CDHB means Canterbury specialists provide regular outpatient clinics and surgical lists on the West Coast. This arrangement, and a deliberate investment in telemedicine technology, provides the West Coast population with improved access to highly specialised services and helps to save people and their families from having to travel long distances for assessment and treatment.

Box 1 Key features of the West Coast population

- WCDHB has an older population structure compared to the national population—27% of its population is aged under 25 years (compared to 32% for NZ) and 21% of its population is aged 65+ years (16% for NZ).
- WCDHB has a lower proportion of Māori (12%) and Pacific (1%) compared to the national population.
- Ngāi Tahu is the iwi with mana whenua status on the West Coast. There are two Ngāi Tahu rūnanga on the Coast—Ngāti Waewae and Makaawhio.
- Census 2018 data shows that just over half the West Coast population lived in small urban area and 45% lived in a rural area.
- The NZ Index of Deprivation 2018 shows that the West Coast has a more deprived population overall compared to the national population. Over one-third (37%) of people in small urban areas lived in a quintile five neighbourhood (the most deprived 20% of areas in New Zealand). The Buller District is the most deprived of the three territorial authorities, with 42% of people living in quintile five neighbourhoods.
- Like many other rural areas in New Zealand, the population of the West Coast is projected to decline (a 4% decrease over the next 15 years).
- The Māori population will grow and the West Coast will continue to age—by 2035 one-in-three people will be aged 65+ years.

2.1.2 Population need for mental health and addiction services

The New Zealand Health Survey estimates for 2014–2017[6] suggest that the West Coast has a higher age-standardised prevalence of mood disorders (depression and/or bipolar, 17.5%) compared to the national rate (15.4%). The unadjusted estimate for WCDHB (i.e. what the population actually experiences) is statistically significantly higher. Prevalence of all mental disorders (mood disorders, anxiety, psychological distress) among West Coast adults has increased since the 2011–2014 period.

The Health Quality and Safety Commission reports that WCDHB had significantly higher rates of people dispensed antidepressants and antipsychotics in 2018 compared to the national rate.[7]

[6] https://www.health.govt.nz/publication/regional-results-2014-2017-new-zealand-health-survey
[7] https://www.hqsc.govt.nz/our-programmes/health-quality-evaluation/projects/atlas-of-healthcare-variation/mental-health/

WCDHB had the highest suicide rate of all DHBs in New Zealand from 2012–2016.[8] The numbers are small but the rate is still statistically significantly higher than the national rate. Provisional data from the Coroner (Figure 2) shows that the number of deaths dropped in the most recent financial year however suicide remains a serious concern for the DHB and its communities.

Figure 2 Provisional suicide numbers for West Coast DHB

18(d)

Source: Coronial Services of New Zealand[9]

Approximately 5 percent of people (~1600) on the West Coast used secondary mental health and addiction services in 2018/19.[10] The vast majority of these people used DHB provided services—only 9 percent accessed services from an NGO only.

2.1.3 Manaakitanga is the mental health facility in Greymouth

Currently, the DHB MHAS based in Greymouth stretches north up to Punakaiki and Reefton (approximately the halfway way point on the two main roads between Greymouth and Westport). To the south, the Greymouth-based MHAS region extends to just north of Hokitika. Additionally, there are specialist mental health services available during business hours in the towns of Westport and Hokitika. Inpatient care and after hours crisis services are provided to the whole district from staff based in Greymouth.

The Manaakitanga unit at Grey Base Hospital in Greymouth co-locates inpatient and outpatient activity with the broader Mental Health team workspace located alongside. Manaakitanga has a nine bed acute inpatient unit (five single rooms and two double rooms).

WCDHB has historically had a high inpatient admission rate, likely to be the result of a range of factors including rurality, access to crisis services, risk profiles, concerns about suicide rate, and access to alternatives to inpatient care.

[8] https://www.health.govt.nz/publication/suicide-facts-data-tables-19962016

[9] https://coronialservices.justice.govt.nz/assets/Documents/Publications/Provisional-Figures-August-2019.pdf

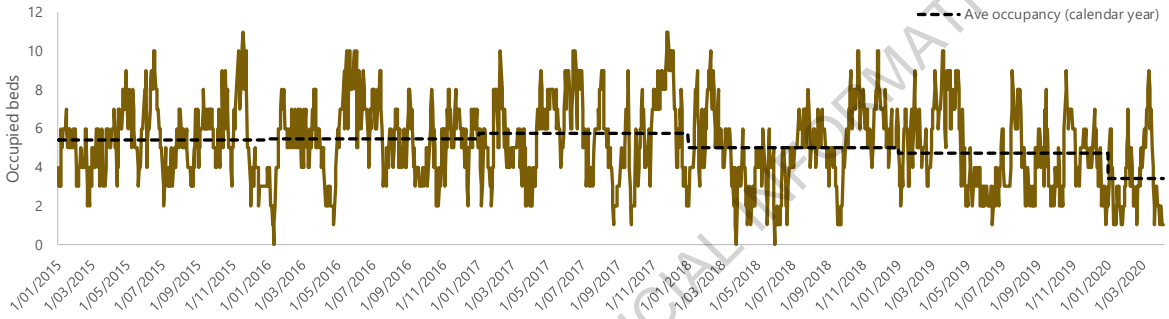
[10] https://nsfl.health.govt.nz/accountability/performance-and-monitoring/mental-health-alcohol-and-drug-addiction-sector

In 2018/19, just under half (48.3%) of West Coast residents admitted to inpatient services had received pre-admission care from community-based specialist services in the seven days prior to admission, which was lower than the national rate of 56.3 percent and the national target of 75 percent.[11] Seventy-one percent of people received post-discharge community contact within seven days—slightly higher than the New Zealand rate (66.5%) but below the national target of 90 percent.

Inpatient occupancy has reduced on average but is still volatile

Figure 3 shows that average occupancy in the Manaakitanga inpatient ward has gradually reduced, but that there can be spikes exceeding the available bed capacity (the current nine bed capacity has not been exceeded since early 2019).

Figure 3 Overnight occupancy in Manaakitanga inpatient ward



Source: West Coast DHB

2.1.4 A mental health and addictions review informed the model of care

Significant efforts from a wide range of stakeholders led to the Mental Health and Addictions Service Review 2014 which articulated a direction of change for future mental health and addiction services.

The Review supported:

- the development of a stepped care approach across primary, community and specialist services
- locality-based integrated comprehensive services
- retaining inpatient care - but considering the optimal size of a sustainable acute inpatient service
- changing the shape of acute and crisis services
- centralising specialist services; adapting dementia services; as well as those for children and young people.

Additionally, the Review provided qualitative information gathered from many contributors and key informers from the West Coast district. This included the perspectives of service users and key

[11] https://www.mhakpi.health.nz/Data/Data/ADULT-ENDING-2019-06-30

stakeholders on the current services as well as areas of need. One hundred and eighty people from all parts of the West Coast MHAS presented their views.

Consumers and their families and whānau, in particular, gave strong, clear feedback. Their issues centred on access, inclusion, continuity, recovery and strengths-based approaches, peer support and community participation. There are gaps in areas of importance to consumers and their families and whānau, such as a lack of planned and acute respite and little opportunity for meaningful activities.

Since the Review was undertaken, the DHB has progressed work in facilities development, primary and community and transalpine service delivery, further embedding a systems wide approach that includes mental health and addictions.

The wider West Coast model of care is the foundation for guiding future developments

The Mental Health and Addictions Model of Care aligns to a wider West Coast health service model of care.

Primary care and community services have a pivotal role to play in shifting the focus from a hospital-centric response to a person-centred focus, recognising that the person will spend the majority, if not all their lives at home, supported by primary care and community services. The model proposes an Integrated Family Health Service (IFHS) structure with a range of services working locally to meet local needs while other services continue to work with a more specialised focus across the district. The IFHS is a locality-based team that is completely focused on understanding and addressing the health needs of its community. The team includes general practice and a range of other primary care services (e.g. district nursing, sexual health) and community mental health and addiction services.

WCDHB is working to develop three integrated locality bases (central, northern and southern) supported by a rural inpatient service and improved coordination services. This direction will improve access to services closer to people's homes, improve clinical support and help to reduce variation, with new standardised and streamlined processes.

It is not always viable to have all services based and delivered locally, so it is critical to identify the services that require a Coast-wide approach to their delivery, flexibly delivering services across the West Coast in response to changing demands in the various areas. A small number of services have been identified as fitting this group including specialist mental health services.

Moving towards an integrated approach between mental health and physical health services

For mental health and addictions services, a stepped care model is being developed that involves the WCDHB service working in partnership with primary and community/NGO organisations to deliver most services in the community, close to where people live. The WCDHB mental health and addictions workforce is envisaged as working at the top of its scope to provide responsive care to people with acute needs and ongoing support to primary and community services so crises are avoided and the system becomes proactive rather than reactive. Greater use of technology, including phone and

internet based services will support early intervention and self-managed care with access to support networks across the community.

The proposed model of care includes two main elements—planned integrated mental health care and the specialist MHAS.

Planned integrated community mental health care could be provided from locality bases. This will have a focus on enhancing self-care, access to brief talking therapies (or alternatives) and integration with primary and community health, PHO mental health services and NGOs. It is envisaged that the majority of service activity will be delivered and led by the nursing and allied health workforce in conjunction with general practitioners, supported by specialist services when needed.

Acute response would follow the same pattern as an acute response to physical health – one where the local service works to the scope and skill level available and, if required, stabilises ready for transport/transfer to the specialist service. More locally responsive acute services (crisis assessment and treatment, respite options) are being developed.

The WCDHB MHAS will continue to provide specialist clinical services. Not all components of this service will necessarily be located in Greymouth. There will always be a small number of people who require longer term engagement with specialist teams because of their condition and/or their inability to respond to other options. Partnering with other agencies/teams will assist people requiring ongoing care and support.

Hospital admission is needed for people with psychiatric and behavioural problems that cannot be managed in any other setting, with close links to physical health care services. Inpatient services will be available for those who need this level of intensity but the focus will be on getting people back into their own community as quickly as possible with the necessary supports from primary and community services to prevent readmission. The need for inpatient beds is expected to reduce over time as viable alternatives are developed in the community such as assertive home-based treatment service.

Some clients may require more intensive therapies and care from other partners and agencies including the CDHB.

2.2 Investment objectives, existing arrangements and business needs

This section includes:

- a summary statement of the problem and description of the ways in which the problems play out
- a set of complementary investment objectives and outline of business needs and key service requirements
- consideration of the benefits and risks of the investment.

2.2.1 The problem definition is clustered under three headings

An Investment Logic Mapping (ILM) workshop was held with key stakeholders on 8 April 2020. The workshop was facilitated by external consultants. The stakeholder group considered the causes and consequences of the key problems. Three problem groupings were identified:

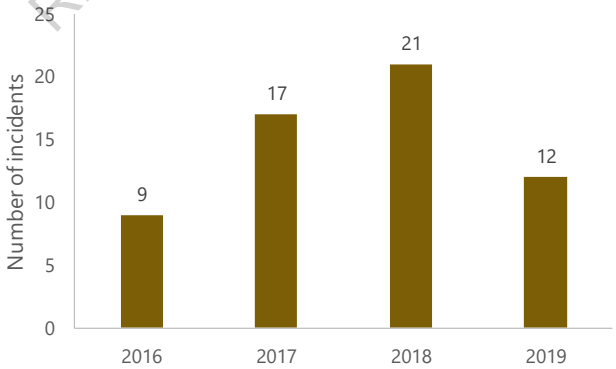
1. Ignores basic rules of a safe and therapeutic environment for consumers and staff
2. Doesn't support positive consumer experience, respect for whānau, and tikanga Māori
3. Doesn't provide connectivity, flexibility and responsiveness that enhances service resilience and integration

The output of the ILM workshop—the Investment Logic Map—is contained in Appendix A. Below we further describe these problems.

Problem one – ignores basic rules of a safe and therapeutic environment

The suboptimal configuration of the unit compromises consumer and staff safety. The unit does not provide the physical design features that best support de-escalation and management of agitation. Incident data (Figure 4) shows that assaults or abuse/threats/harassment against staff occur at least monthly on average, as shown in.

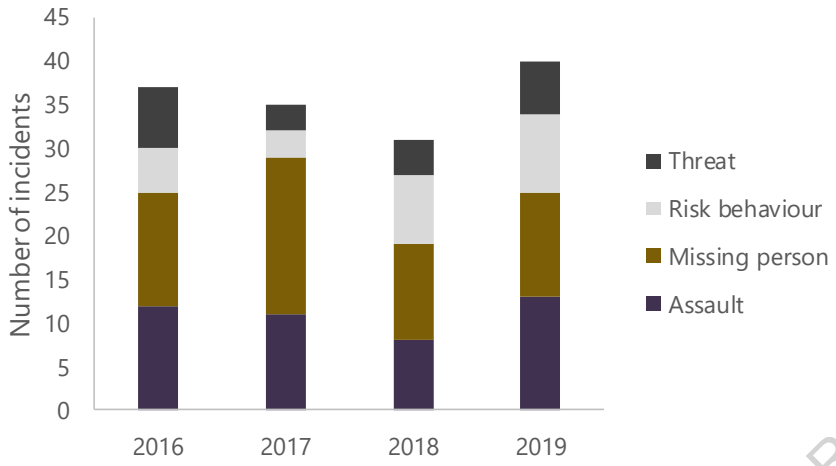
Figure 4 Employee incidents (assault + verbal abuse/threats/harassment/bullying)



Source: West Coast DHB

The small inpatient unit reports a significant number of patient behaviour incidents each year including assaults/ threats and missing persons (Figure 5).

Figure 5 Patient behaviour incidents



Source: West Coast DHB

The design and layout of the existing high care area and seclusion room is not fit for purpose and creates safety issues. For example, there is a large concrete pillar directly outside the door of the seclusion room that narrows the access way. Staff report a number of injuries entering and exiting the room and consumers sometimes use the structural pillar (e.g. grab hold of) to resist staff.

A ligature review report from 2018 identified a large number of ligature points throughout the unit, including (for example) exposed pipes and door handles, replacement of which comes at a substantial cost.

Safe access to the unit is currently limited. The secure entrance routes people directly through the high care area. This means that if a consumer is in that area, secure access to the unit is unavailable and may lead to a distressed person being brought through the main entrance and ward, with a resulting lack of dignity.

The Ministry of Health National Asset Management Plan (NAMP) Clinical Facility Fit-for Purpose workstream[12] noted that all but two of the bedrooms are undersized (compared to the Australasian Health Facility Guidelines) and most have shared bathroom facilities (one single room and one double room have ensuites). There are only two shower rooms. The unit does not provide appropriate facilities for gender safety considerations. For example, staff highlight the inappropriateness of shared bathroom facilities for females with trauma histories.

The NAMP review team noted that there is inadequate indoor exercise space and limited outdoor space.

The low stimulus area is designed as a seclusion room and is described as very sterile, with little opportunity to upgrade the area.

[12] Macfarlane, R. 2019. Clinical Facility Fitness for Purpose West Coast District Health Board. Ministry of Health.

Problem two – doesn't support positive consumer experience, respect for whānau and tikanga Māori

Consumer experience is negatively impacted from the entry to the facility through to the low stimulus area. The facility offers no ability for people to have visits with whānau and other support people off the main ward (i.e. lack of safe and appropriate whānau room/visitors room). A recent example cited by staff was the admission of a young person, where a number of friends wanted to be with the person and no way to facilitate this (as it would be inappropriate to bring a group of teenagers onto the ward).

The current access does not provide an appropriate level of dignity and respect for consumers, for example, police arriving at the front door while other areas can look in (Radiology, dementia unit, Emergency Department (ED), ambulance bay).

The mental health unit is adjacent to the dementia unit, which has confused, frail and elderly people entering and exiting (visitors or patients being admitted/discharged). When this coincides with a distressed person being brought to the mental health unit (e.g. displaying disinhibited behaviour) it results in an upsetting experience for visitors to the dementia unit and a lack of privacy and dignity for the mental health consumer.

Consumer feedback relayed by staff describes the high care area as oppressive, cold, sterile and 'feels like being in jail'. Feedback from the mana whenua advisory group is that the inpatient unit is a bad environment for Māori, who are over-represented in admissions.

There is a lack of privacy within the unit and incidents are often very public. For example, the door from the high care area opens into the kitchen and dining area (leading to the lounge), so any event that occurs during mealtimes is very visible to other consumers. Poor acoustic management creates potential confidentiality issues, with staff offices next door to the consumer lounge.

Problem three – doesn't provide connectivity, flexibility and responsiveness that enhances service resilience and integration

This problem expresses itself in a number of ways—the inability for a small unit to be connected to other services and support, the lack of options for staff to appropriately manage different cohorts, and a deterioration of the building that makes it less and less cost effective to remediate.

Connectivity

With the demolition of the existing hospital building the Manaakitanga unit will be dislocated from other services in the main hospital and Integrated Family Health Centre. This dislocation will put staff and consumers at risk with emergency response to critical incidents having to come from the other end of the campus. It will also reduce ease of access and way finding for consumers and whānau.

Flexibility

Accommodation is not reflective of the consumer journey or adaptable to different levels of acuity. The unit has four single bedrooms and two double rooms in a corridor, with the final bedroom around the corner. This means that, in order to avoid safety risks, the final bedroom is not able to be used flexibly.

The continuation of double rooms is out of step with modern units. The service highlights the inappropriateness of double rooms when the unit is full, with the example of 9(2)(a) [redacted]

[redacted]

Building deterioration

The Manaakitanga building is believed to have been constructed circa 1978. A high-level building report prepared by Beca on behalf of the Ministry of Health NAMP team found that the roof is nearing end of life, HVAC plant servicing the building are in poor condition and cold water services are showing signs of age. The ground floor fitout is largely original and showing its age. Finishes are well worn and electrical and data infrastructure is likely out of date.

A detailed engineering evaluation of the building conducted by Opus in 2012[13] noted some deterioration of the building including:

- Cracking and possible spalling of concrete in some areas of the lower ground floor external walls and extensive cracking in the walls surrounding the storage area
- The brick veneers at lower ground level are typically pulling away from the concrete walls behind, possibly due to corrosion of tie wires behind the brick veneers

The service reports a current state of general disrepair of the building. Windows are single glazed and in poor condition. Some leak and there are widespread reports of unacceptable wind noise and air leakage through the opening sashes. Temperature control is incredibly difficult, particularly in the high care area.

There is no suitable back of house entry for service flows such as linen and food, with all services having to come through the front door.

2.2.2 Investment objectives that seek to directly address the key problems

In response to the problems identified, key stakeholders and external consultants developed and circulated a set of investment objectives that seek to directly address the issues:

1. Fit for purpose, modern and therapeutic environment that is safe for consumers and staff
2. Positive consumer experience by a facility that demonstrates respect for whānau and embeds tikanga Māori
3. Flexible, connected and responsive service that is resilient and integrated with other services

[13] Opus. 2012. Detailed Engineering Evaluation Quantitative Assessment Report Grey Base Hospital Acute & Community Mental Health Services Building.

Below, we summarise the current state (as per the problem definition above) and business needs under each investment objective.

Objective 1: Fit for purpose, modern and therapeutic environment that is safe for consumers and staff	
Existing arrangements	The desired, contemporary model of care cannot effectively be implemented in the current facility. The unit is over 40 years old, tired, and converted from an old maternity wing. The building's structure, layout and physical environment is not fit for clinical purpose. Outdoor and activity spaces are inadequate for a modern therapeutic environment. Consumer feedback reflects the sterile nature of the high care area. The layout of the unit compromises consumer and staff safety as evidenced by incidents reported in the small unit.
Business needs	A facility that provides safe and functional clinical relationships; and supports contemporary, patient-centred models of care. Provides physical and psychological safety. Provides a warm and comforting environment that promotes wellness and positive therapeutic outcomes.

Objective 2: Positive consumer experience by a facility that demonstrates respect for whānau and embeds tikanga Māori	
Existing arrangements	Consumer experience is negatively impacted from the entry to the facility through to the high care area. There is a lack of privacy and dignity for consumers and whānau, including overlooking of arrivals by other areas and events on the ward occurring in very public ways due to adjacencies within the unit. The current unit does not reflect tikanga Māori, and inadequate facilities limit the ability of whānau to support the consumer journey.
Business needs	A unit that is welcoming and home-like, with an appropriate level of privacy to maintain the dignity of consumers and whānau. Opportunities for whānau involvement in consumers' recovery journey are available in suitable facilities. Recognises local culture, heritage and Te Ao Māori.

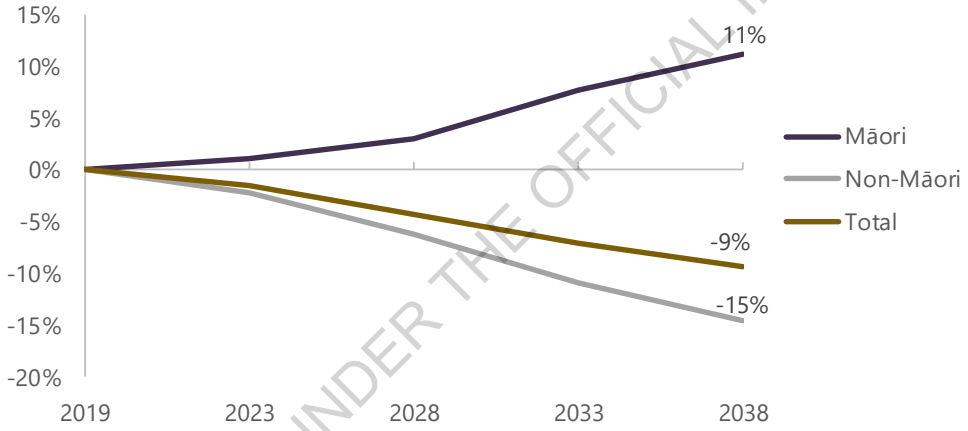
Objective 3: Flexible, connected and responsive service that is more resilient and integrated	
Existing arrangements	Accommodation is not reflective of the consumer journey or adaptable to different levels of acuity. There is no ability to cohort people according to their particular needs and the high care area is severely limited. The unit will be left at the opposite end of the campus from the new Te Nikau building when the old hospital is decommissioned/ demolished, reducing support from, and integration with, wider hospital

	services. The building itself is deteriorating and does not meet current guidelines (e.g. service entry or bedroom sizes).
Business needs	Promotes sustainability and provides a flexible, future-focussed development strategy. Physical environment is flexible and can adapt over time in response to changes in practice and treatment. Ability to cohort people according to acuity, vulnerability, demographic or other needs. Promotes integration of inpatient services with community services, and mental health services with physical services.

2.2.3 Determining bed requirements for the future

In order to model potential bed requirements for the future, a demographic-driven projection of bed nights using current utilisation data and WCDHB population projections (by ethnicity, age, gender) was generated. The result of this demographic driven projection on total bed nights is shown in Figure 6. It reflects the changing size and mix of the service user population over the next two decades.

Figure 6 Projected change in bed nights by ethnicity, percentage on 2019



Source: West Coast DHB, Statistics New Zealand, Sapere projection

Two different methods have been used to turn projected bed nights into required bed numbers. The first applies an average occupancy planning benchmark. Total annual bed nights are divided by 365 and then divided by an average occupancy percentage. Service planners often use 85 percent as a planning assumption. In the case of a small unit such as Manaakitanga, a 70 percent assumption is likely more appropriate.

A second method attempts to plan for variance in access by taking the projected bed nights for each year and distributing them across the 365 days of the year, according to the distribution in the 2019 calendar year. For various percentiles of daily occupancy:

- the 95th percentile means that there are enough beds on all but ~18 days (5%) of the year
- the 97th percentile means that there would be enough beds on all but ~10 days (3%) of the year
- the 99th percentile means that there would be enough beds on all but ~3 days of the year.

Planning method	2019	2023	2028	2033	2038
99th percentile	9.0	8.9	8.6	8.4	8.2
97th percentile	9.0	8.9	8.6	8.4	8.2
95th percentile	8.0	7.9	7.7	7.4	7.2
70% ave occupancy	6.7	6.6	6.4	6.2	6.1

The results of this 'status quo' projection suggest that, if there was no change to patterns of inpatient utilisation, between seven and nine beds would be required, and would need to be maintained out to 2038 (although the occupancy rate would be expected to reduce over time).

The intent of the West Coast mental health and addictions model of care is to reduce the need for inpatient admission over time, by optimising available crisis respite options and developing viable alternatives in the community. No target has been set for the number of admissions diverted to community alternatives, however, scenario modelling demonstrates that a relatively modest reduction in the admission rate (5%) would reduce the peak requirement to eight beds by 2033. In real terms, a 5 percent reduction in admissions translates to around seven fewer admissions based on 2019 numbers.

In a rural setting it is often harder to reduce length of stay, as discharge planning takes into account the potentially long distances people live from the unit. However, a half-day reduction in average length of stay, combined with a diversion of 5 percent of admissions, would mean the peak bed requirement of eight could be achieved around the time of a new facility opening (2023).

2.3 Potential scope and service requirements

The scope and service requirements are described in two key documents: the site masterplan and the Functional Design Brief.[14]

The mental health facility will house centralised mental health and addiction specialist services for the population of the WCDHB including:

- acute mental health and addiction inpatient care
- crisis response including intensive community care
- complex Alcohol and Other Drug (AOD) services and co-existing disorders
- Infant Child and Adolescent Mental Health Services (ICAMHS)
- Māori Mental Health.

Some consumers may require more intensive therapies and care, therefore the WCDHB will maximise utilisation of networking relationships with other facilities providing inpatient mental health and addictions services in Christchurch, Blenheim, and Nelson.

[14] Johnson R. 2020. Functional Design Brief Manaakitanga Inpatient Unit West Coast DHB. Jacobs.

The inpatient unit will provide resources for the delivery of short to medium term inpatient assessment and treatment services for people, typically aged 18 to 64, experiencing moderate to severe episodes of mental illness who cannot be adequately treated in a less restrictive environment or community based setting.

It is assumed that with increasing capacity across primary and community services in the region, that the demand for inpatient beds will reduce over time. On this premise the proposed facility is based on eight inpatient beds plus an admissions zone which includes low stimulus spaces.

While there are specialised clinical needs within the inpatient unit, bed spaces should be adaptable and flexible wherever possible to provide for a range of care types during periods of fluctuating activity. The eight bed unit will comprise six beds which may be paired or clustered to provide for different cohorting plus a two bed pod for high needs care.

Ambulatory and outpatient care for the MHAS and ICAMHS will be provided primarily from the Grey Base Hospital IFHC or in community settings.

Key service requirements

The unit will provide a welcoming environment. Access to natural light and pleasant outlook is essential for all areas to enhance a homelike, friendly and culturally appropriate environment.

The layout needs to be sufficiently flexible to allow for changing levels of acuity, age mix, genders and models of care over time. The ability to create pods/clusters for distinct service user groups (e.g. based on gender, age, diagnosis or acuity) is desirable.

A variety of daily living spaces will provide the opportunity for socialisation or individual personal space/quiet time. Lounge/dining areas may be open plan but require a degree of separation. Activity spaces need to accommodate a range of treatment options from passive to active e.g. music therapy, interactive diversional group activities and activity spaces should generally open to outdoors.

There will be a separate service support access for the delivery of meals, stores and the removal of waste. Contemporary workspace environment will be provided for the MHAS teams.

The Functional Design Brief outlines the key functional requirements as they relate to the proposed new facility.

Admission

Direct admissions to the unit will be facilitated by community based care providers and MHAS teams including crisis care. Admissions may also be coordinated from within the Grey Base ED and/or IFHC.

Ambulatory/day programmes

The MHAS will provide a number adult, adolescent and paediatric ambulatory services from the Grey Base IFHC.

Low stimulus environment

The inpatient unit accommodation will provide low stimulus rooms and sensory modulation rooms to provide a therapeutic environment to support care and management of service users. This approach is consistent with Zero Seclusion 2020.

Non-clinical support

All support for the stand-alone inpatient unit including food services, supply and environmental services will be provided from services based within the Grey Base Hospital. Separate point of access into the Mental Health unit will be provided as a service entry.

Mental health tribunal

Provision for mental health tribunal hearings within the mental health unit is required. The intent is to utilise a meeting room on the perimeter of the unit which is multipurpose in nature. It will require two points of egress.

Safety and security

The facility will be compliant with all guideline recommendations for mental health service including anti-ligature.

Whānau and visitor

Provision for inclusion of family/whānau/carers and visitors is important to promote a recovery based model. The facility will provide a variety of internal and external spaces for care, support and social interactions.

Workspace

Contemporary workspace environment will be provided for the MHAS teams including administration, nursing, allied health, medical, operational team, Grey Community Mental Health, crisis team, AOD, ICAMHS, students.

2.4 Key benefits and risks of this proposal

This section includes the potential benefits and risks of the investment identified at this initial stage of the project.

2.4.1 Benefits align to the wellbeing framework

The Treasury's Living Standards Framework (LSF) describes the Four Capitals—natural, human, social, and financial and physical assets—that generate wellbeing.[15] The LSF includes 12 domains of current wellbeing, reflecting its current understanding of the things that contribute to how New Zealanders experience wellbeing.

[15] https://treasury.govt.nz/information-and-services/nz-economy/living-standards/our-living-standards-framework

This proposal is for investment in hospital facilities (physical capital) from which we expect to see benefits in the following domains of wellbeing in the LSF: health, cultural identity, safety and security, subjective wellbeing.

The ILM stakeholder workshop identified an initial set of benefits and possible key performance measures. The set was discussed and expanded in a benefits workshop on 18 May 2020. The set of expected benefits and their alignment to the LSF is outlined below. We return to the domains of wellbeing later in the Economic Case. Benefits management is addressed in the Management Case.

LSF domain	Benefit	Measures	Who benefits?	Direct or indirect?
Health  Subjective wellbeing 	Improved recovery / wellness outcomes	Average length of stay (days)	Consumer DHB	Direct
		Improvement in average HoNOS scores from admission–discharge	Consumer	Direct
		Proportion of inpatients with a HoNOS improvement of 4+	Consumer	Direct
		Readmission rate (%)	Consumer DHB	Indirect
		Number of acute inpatient discharges	Consumer DHB	Indirect
		Consumer reported experience	Consumer	Direct
Subjective wellbeing  Cultural identity 	Improve consumer experience and participation and embed tikanga Māori	Number of complaints & compliments	Consumer DHB	Direct
		Consumer reported experience	Consumer	Direct
		Rate of engagement with the Māori Mental Health Service	Consumer DHB	Indirect
		Proportion of Māori service users with a completed cultural assessment	Consumer	Indirect
		Time to cultural assessment for Māori service users	Consumer	Indirect
Health 	Increased service integration, sustainability, resilience	Proportion of discharges with ≤2 night LOS (i.e. likely to be crisis respite)	Consumer DHB	Indirect
		Time from ready to discharge to actual discharge	Consumer DHB	Indirect
		Proportion of long length of stay outliers (LOS>upper quartile+1.5*interquartile range)	Consumer DHB	Indirect
		Proportion of discharges with a community contact within 7 days	Consumer	Indirect
		Proportion of inpatients that have accessed primary care (LTC programme)	Consumer	Indirect
		Rate of non-attendance at community mental health team appointments	Consumer DHB	Indirect
Safety & security		Number of complaints	Consumer	Direct

LSF domain	Benefit	Measures	Who benefits?	Direct or indirect?
 Subjective wellbeing 	Reduced harm to consumers	Number of seclusion events	Consumer	Direct
		Average duration of seclusion event (hours)	Consumer	Direct
		Rate of sedative medication use (balancing measure)	Consumer	Indirect
		Personal restraint incidents	Consumer	Direct
		Environmental restraint incidents	Consumer	Direct
		Patient behaviour incidents (all SAC levels)	Consumer	Direct
Safety & security  Subjective wellbeing 	Reduced harm to staff	Employee incidents (all SAC levels) – including assault, abuse, threat	Staff DHB	Direct
		Average sick leave days per FTE	Staff DHB	Direct
		Annual leave days taken per FTE	Staff DHB	Direct
		Overtime rates	Staff DHB	Direct
		Number of workplace injuries (ACC)	Staff DHB	Direct
Subjective wellbeing 	Improved staff wellbeing	Vacancies (sum of FTE vacancies over the year)	Staff DHB	Direct
		Proportion of staff satisfied	Staff	Direct
		Average sick leave days per FTE	Staff DHB	Direct
		Staff turnover	DHB Consumers	Direct
		Staffing matches acuity of patients (TrendCare)	Consumer DHB	Indirect
Time use  Jobs & earnings 	Return to work or leisure	Not measured or assumed from ALOS	Consumers Society	Indirect

2.4.2 Risks in a construction project

The main risks are cost escalation, particularly given the unique context of the West Coast, and potential delays. The construction market is facing considerable uncertainty due to COVID-19 impacts. The key risks identified at an early stage are set out below. Mitigations and the approach to risk management are discussed in the Management Case.

Risk	Consequence	Likelihood	Risk level
Tight construction market may mean it is difficult to engage an appropriate main contractor.	Severe	Likely	
Unexpected costs or cost escalation may result in the need to request additional funding to complete the project.	Severe	Likely	
Delay in construction works impacts overall timeline.	Likely	Moderate	
Changes in scope of project, or changes to design of facility after construction commences increases project costs	Major	Moderate	
Poor integration of contractors may lead to design issues that result in financial and administration issues.	Major	Moderate	
Discrepancies, design errors in consultants' documentation could lead to quality and financial administration issues.	Major	Moderate	
The completed building not fit-for-purpose or does not meet users' needs.	Severe	Unlikely	
West Coast location limits availability of staff and resources	Major	Likely	
Model of care not being implemented in a timely way or project delays implementation of changes in model of care	Major	Moderate	
Sustainable staffing model unable to be delivered due to mismatch of workforce skills	Severe	Unlikely	

3. Economic case: finding the preferred way forward

Having determined the strategic context for the investment proposal and established the case for change, this part of the business case:

- identifies critical success factors
- identifies a range of options available for delivering the required services
- undertakes an initial appraisal of these options to determine a short-list
- undertakes analysis of costs, benefits and risks of the short-listed options.

3.1 Critical success factors

Critical success factors (CSFs) are attributes essential to the successful delivery of the proposal. The following CSFs were agreed by stakeholders.

CSF	Broad description	Proposal-specific factors
Meets business needs/strategic fit	Meets the agreed investment objectives, related business needs and service requirements	Integration with other services (physical and mental health) is critical for this investment
Offers value for money	Achieves an optimal mix of potential benefits, costs and risks	Enables improvements in experience and health/wellness outcomes that wouldn't be achieved without the investment
Capable suppliers with capacity	Aligns with the ability of potential suppliers to deliver the required services and is likely to result in an arrangement that optimises value for money	Likelihood of local contractors to deliver some/all of the services
Affordable	Can be met from likely available funding and matches other funding constraints	DHB has access to capital to meet build costs and can continue to fund the operational costs Does not displace other critical investment priorities
Achievable	DHB can respond to the changes required and option matches the level of available skills required for successful delivery	Can be done in the proposed timeframe with appropriate project resources and support Continuity of service during the investment period Design is informed by key stakeholders (User Group)

3.2 Previous work to determine the placement of a new mental health facility

A site master planning (the masterplan) report was prepared for WCDHB in 2019. The primary driver for the development of the masterplan was the placement of a new Mental Health facility.

Start-up meetings for the site masterplan, held with the DHB Executive Team in June 2019, confirmed the Grey Base Hospital site as the preferred location for a new mental health facility. The inpatient service needs to be provided centrally, and be strongly integrated with physical health services and the wider workforce in the local community mental health team. This means that a facility on the Grey Base Hospital campus is the only realistic option for WCDHB. An off-site option would introduce clinical and safety risks that a small, isolated staff would not be able to mitigate.

As such a series of options were tested which each affected the layout of the masterplan. The masterplan considered both the proposed mental health facility and the future of other buildings in order to develop a series of options which were then refined and selected for presentation to the WCDHB. The masterplan options are included in Appendix B. An option which placed the mental health building as close as possible to the new hospital directly south was selected as it offered the largest advantage overall.

Although an options appraisal was undertaken in 2019 for the masterplan, WCDHB decided to revisit the long list of options for the development of this business case.

3.3 Long list options and initial options assessment

The options for delivering acute inpatient mental health and addictions services in the smallest (population) and most rural DHB in the country are genuinely limited.

3.3.1 Provision of all inpatient care in Canterbury was discussed but not formally included on the long list

The WCDHB Mental Health and Addictions Review and Model of Care determined that short-term acute inpatient services would be available on the West Coast, therefore an option to provide all inpatient services out of Canterbury was discussed, but not formally included on the 'long list'.

That position was reconfirmed for this business case by the Executive Team and leadership of CDHB mental health and addiction services during discussion of the options. The model of care includes general adult acute inpatient services to be delivered on the Coast, so they can be closely integrated with community mental health services, localities, and physical health services. Canterbury remains a referral pathway for highly specialised care.

Shifting general adult inpatient care to Canterbury, requiring the transfer of more than 100 people to Christchurch each year, would result in significant disruption and potential escalation of distress for people at a very vulnerable point in their lives. Importantly, inpatients would be dislocated from whānau and community supports. Additional transport costs would be incurred and may require multiple patient escorts to ensure a safe transfer.

9(2)(j)

[redacted]

WCDHB established a 'User Group' to work with the business case team to revisit the masterplan option, reconsider and appraise the list of potential options for the mental health facility. The User Group was made up of representatives from the inpatient service and community mental health team (medical, nursing and allied health), consumer council members, Māori Health, Finance and WCDHB general management.

The User Group process involved five workshops with the health planning and design team and additional service meetings outside the workshops to confirm the Functional Design Brief and bed numbers. The options investigation was an accelerated process running from March to May 2020. All but one (the first) meeting were conducted virtually, during Government COVID-19 restrictions.

9(2)(j)

[redacted]

The base case is a status quo counterfactual

A base case option is included as the baseline for comparing marginal costs and benefits of alternative options. The base case for this investment proposal is essentially the status quo—continue with the existing facility with minimal planned capital expenditure.

The base case does not enable improved service delivery, fails to meet the investment objectives, leaves the service at a distance to acute and outpatient activity, and still involves some disruption from minor works.

3.3.3 Long list options appraisal

The master planning process had determined the new main hospital building as the primary planning destination at the north end of the upper ground level of the campus. The relationship of all other buildings to the new hospital main entrance, IFHC and ED is key to achieving the following key objectives:

- Concentrate hospital activity to the north for ease of way-finding and reduced travel distances.
- Concentrate clinical and support activities in near proximity to support multidisciplinary inter-professional connectivity.
- Co-locate services for model of care efficiencies.
- Locate all key services at upper ground level away from flood plane.
- Maintain expansion zones for new hospital.
- Safe and walkable site.

The design team presented the set of potential options to the User Group at its first workshop on 20 March 2020. The User Group discussed the advantages and disadvantages of each option over the course of the first three workshops. Following is a description and summary of the key features of each long list option.

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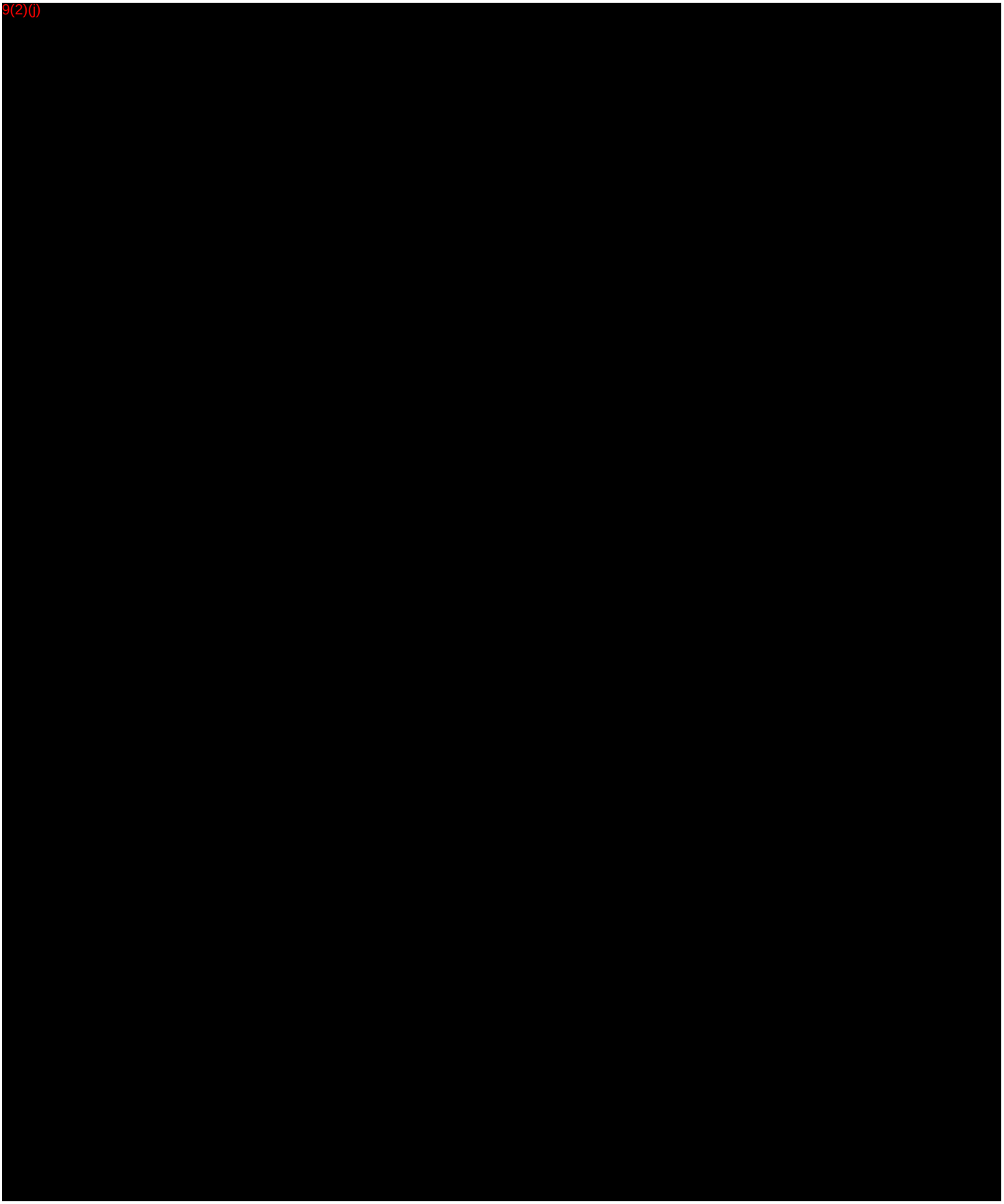

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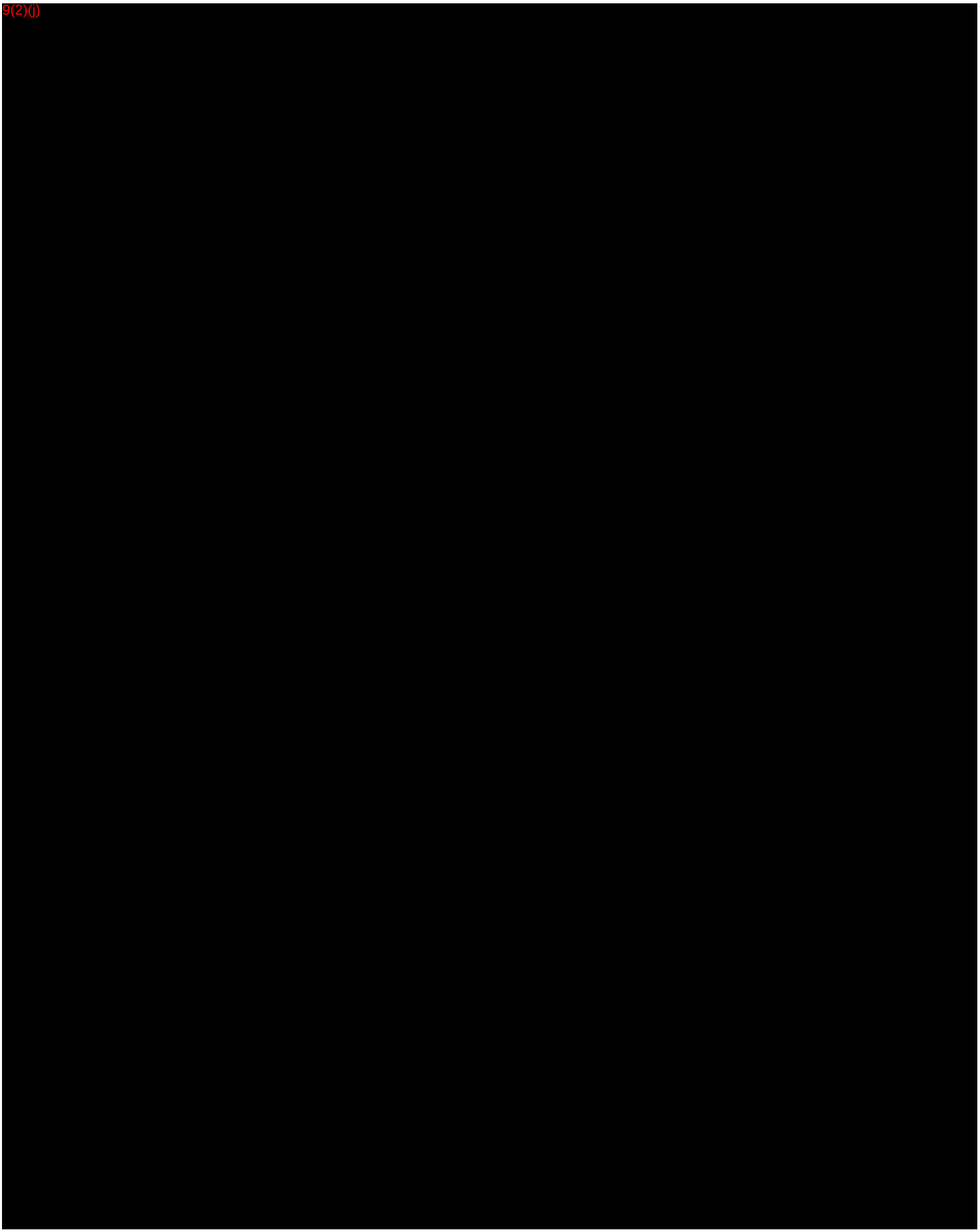

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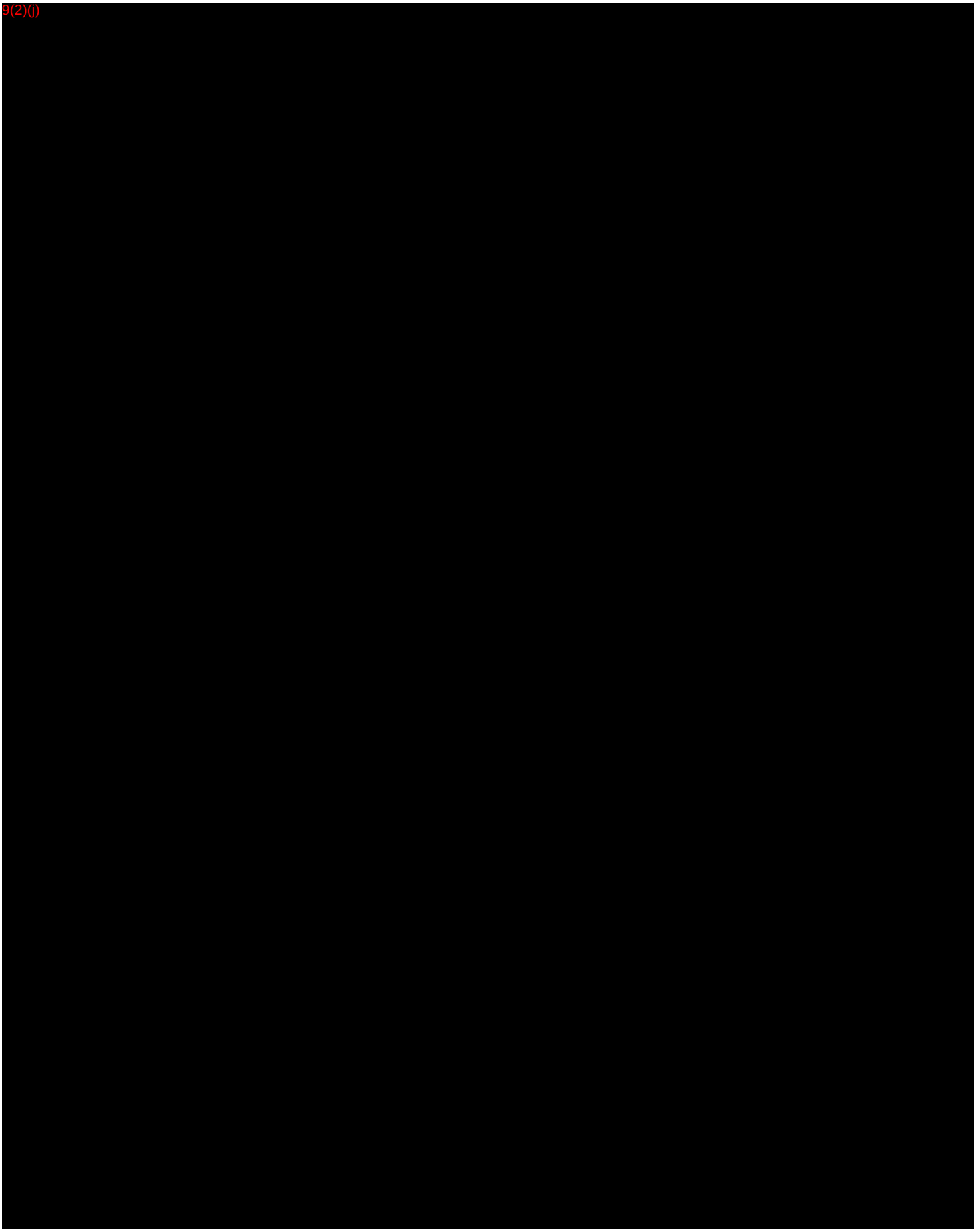

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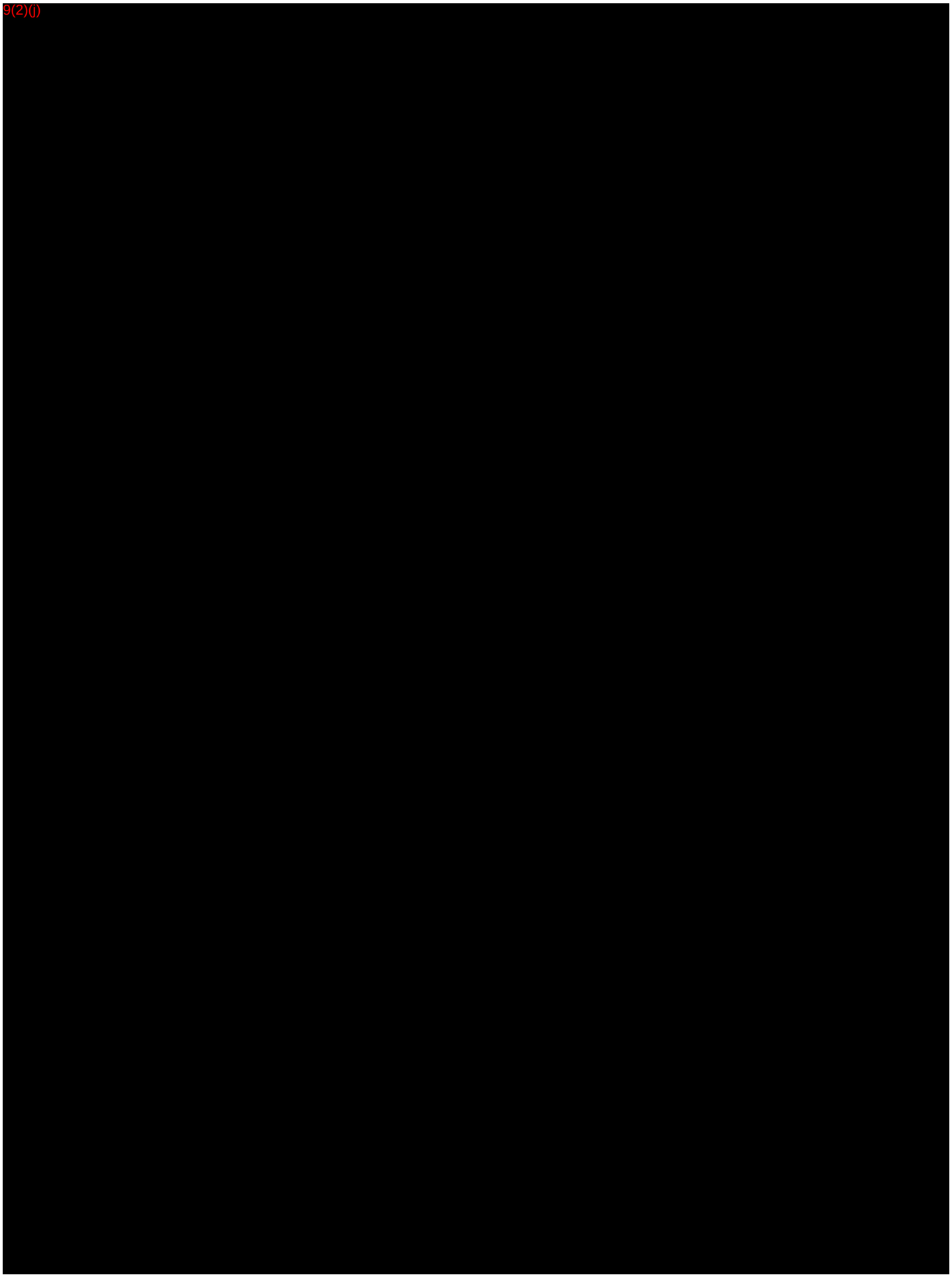
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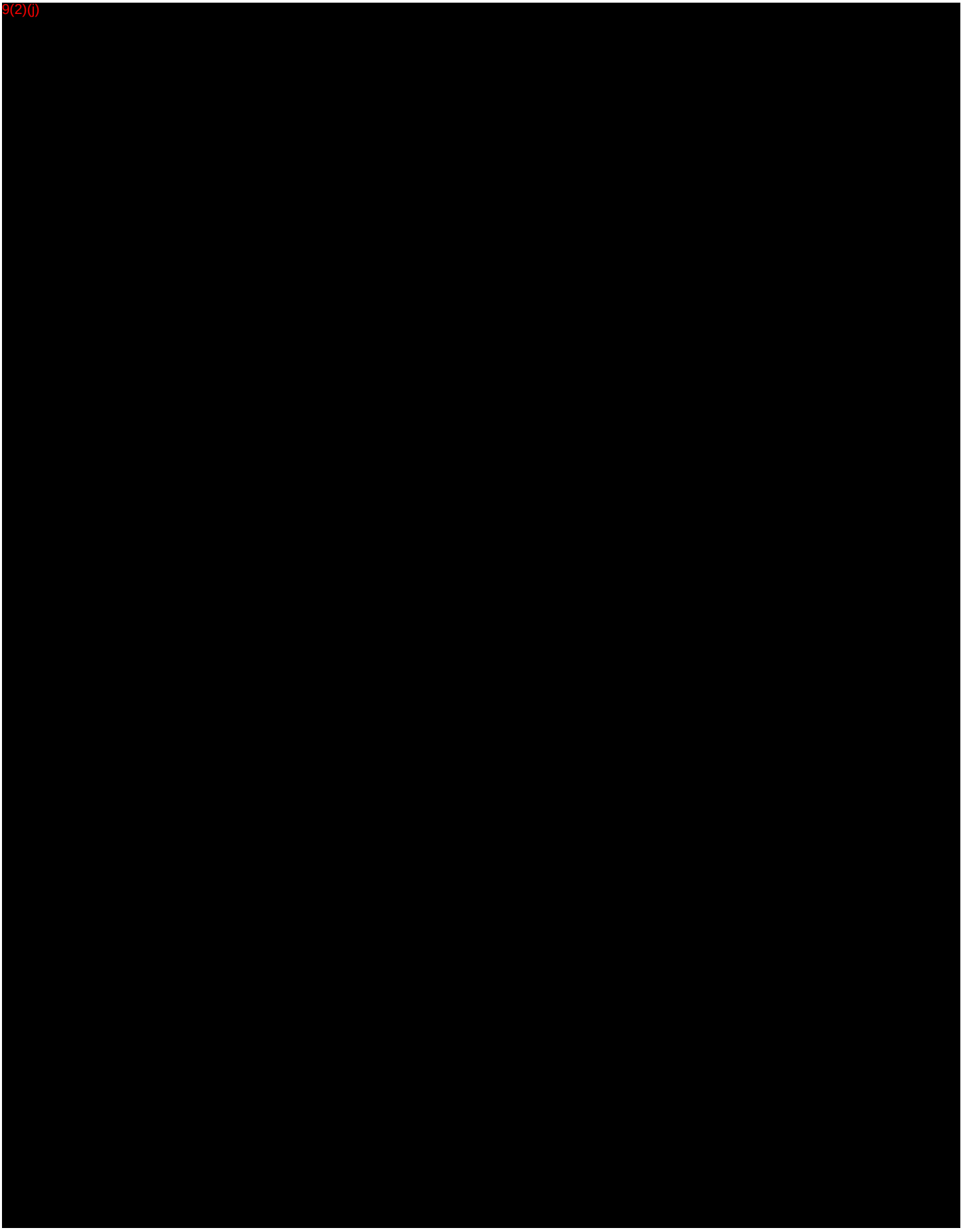

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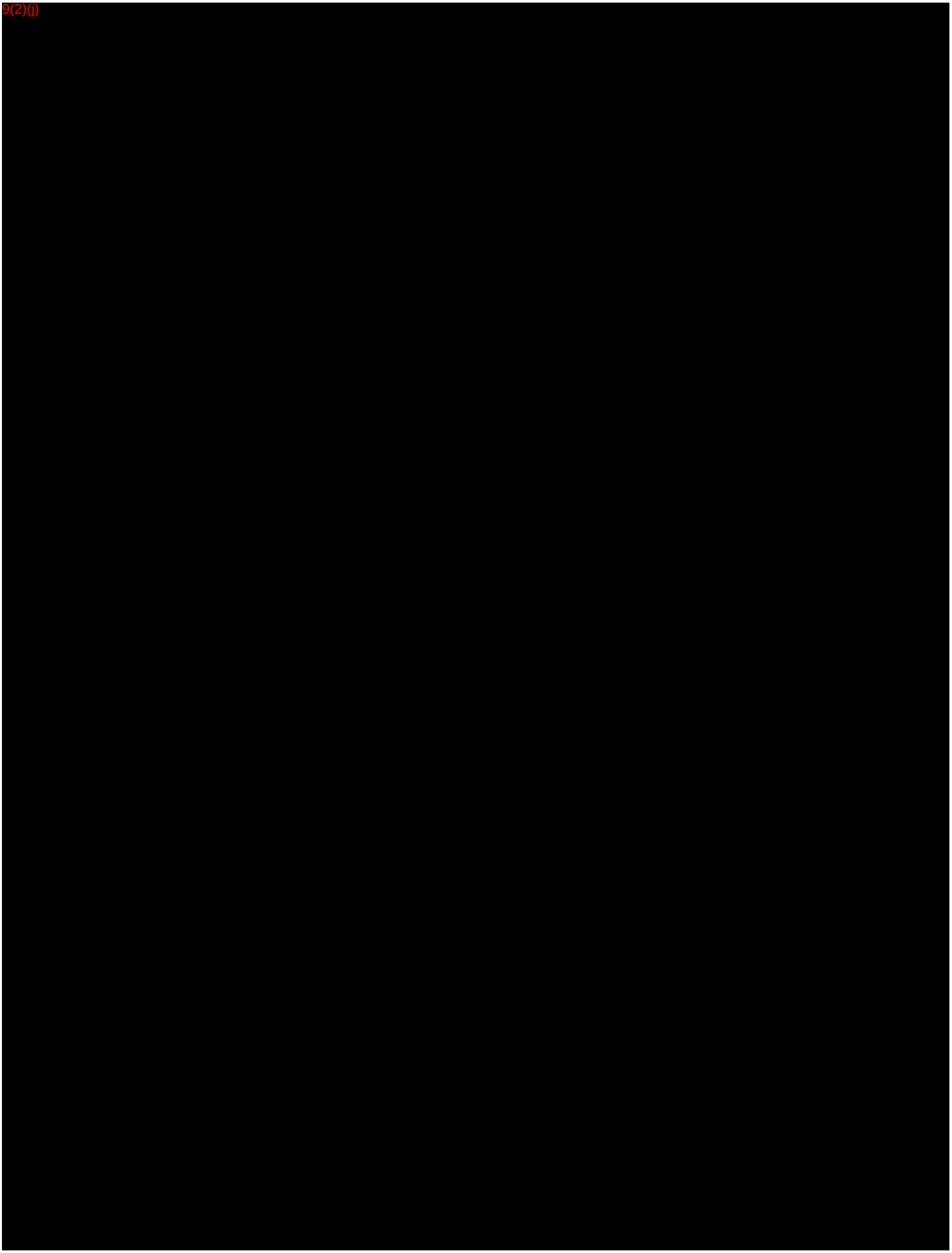

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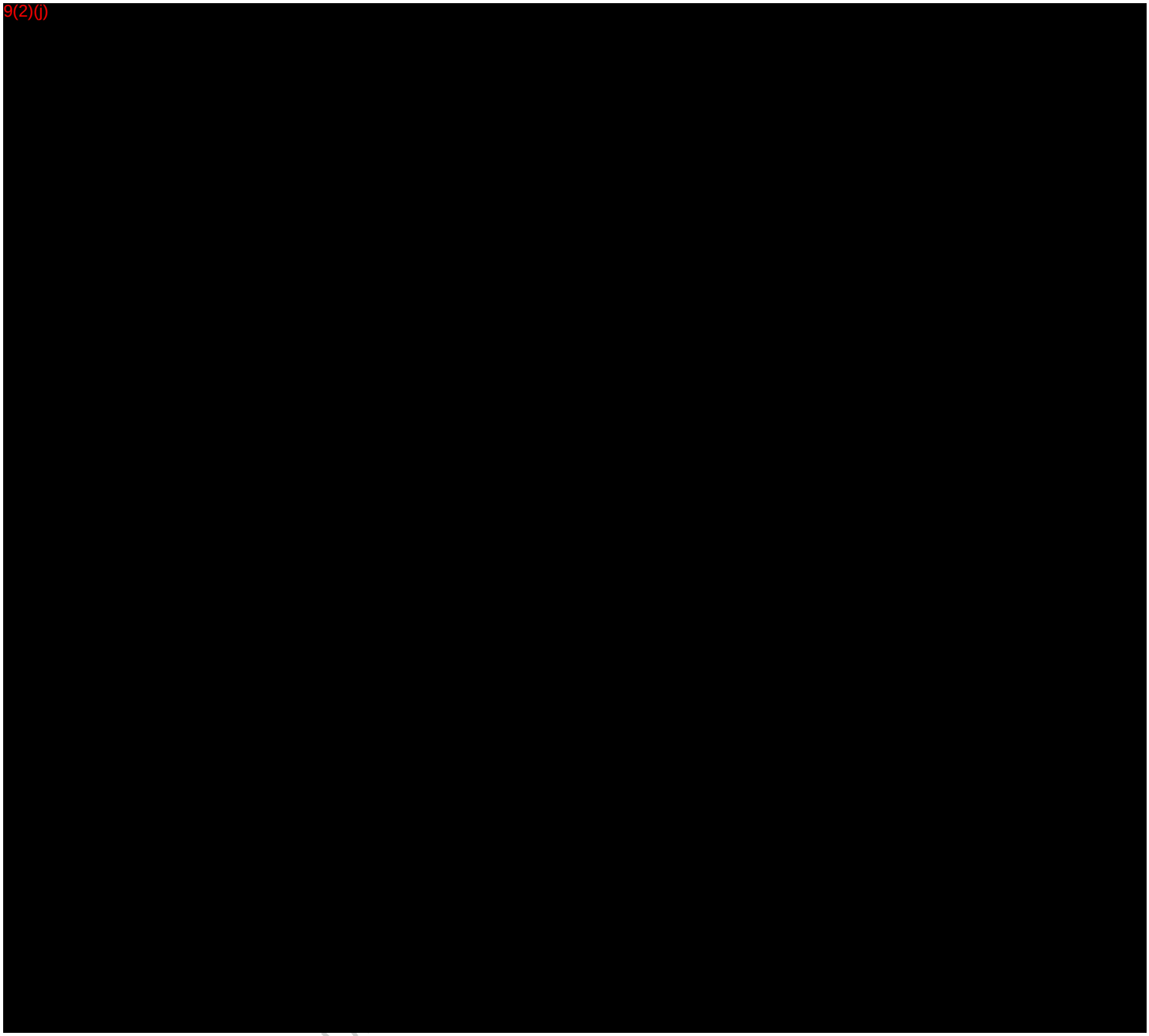


3.5.4 Potential for expansion and provision of consultation space

User Group engagement with the layout plans included discussion of where mental health and addictions outpatient activity would occur. WCDHB has confirmed that its operational model for the Grey Base Hospital site is that outpatient activity will primarily take place in the IFHC. The IFHC has three clinic rooms that are specified for mental health consultations (e.g. two points of egress) and there is provision for short notice consultations.

If space in the IFHC comes under pressure in the future, there may be other options on the campus for provision of mental health and addiction outpatient rooms.9(2)(j)

3.6 Quantitative assessment of the shortlisted options

The quantitative assessment is focused mainly on the costs, because the benefits, although substantial, are difficult to assess quantitatively.

3.6.1 Whole of life costs

The assumptions we make in formulating the present value of the costs are set out in Table 2.

Table 2 Cost assumptions for the Economic Case

Assumption	Description	Source
Period of analysis	30 years from 2023/24 to 2052/53	Modelling assumption
Discount rate	6%	Treasury
9(2)(j) [redacted]	9(2)(b)(ii) [redacted]	9(2)
9(2)(j) [redacted]	(2)(b)(ii) [redacted]	9(2)
Commissioning year	2022/23	Modelling assumption
Phasing of works	2020/21 – 20% 2021/22 – 30% 2022/23 – 50%	Modelling assumption
Residual value	50% of initial cost in year 30	Modelling assumption
Midlife replacement	15% of initial cost in year 15	Modelling assumption
Change in existing costs	No change to personnel costs or to facilities costs	Modelling assumption
Counterfactual ("do minimum")	Assume refurbishment costs equivalent to midlife replacement incurred in 2020/21 and at year 15	Modelling assumption

There is an assumption that there will be no change in operating costs (i.e. that the existing staff composition will remain). With respect to facilities costs (e.g. maintenance) it is often difficult to conclude whether costs will go up or down. The reason for this is that a new building may require a specific, more regular maintenance schedule, or that it is more expensive to replace certain items (e.g. windows). Alternatively, a new build requires less maintenance because the building uses materials that are more durable.

We have also modelled a base case 'status quo' scenario. This is illustrative and has not been fully costed at this stage. It is important to note that there are costs associated with the existing facility which need to be taken into account relating to refurbishment and replacement. We have assumed that there will be two replacement spends over the period of analysis and that there will be no residual value relating to the facility.

Table 3 Whole of life capital costs

	Base case	Option A	Option B
Present value of initial capital investment		9(2)(b)(ii)	[redacted]
Present value of mid-life replacement	9(2)(b)(ii)	[redacted]	[redacted]
Less present value of residual value	9(	[redacted]	[redacted]
Net present value of costs	9(2)(b)(ii)	[redacted]	[redacted]
Compared to the base case		9(2)(b)(ii)	[redacted]

Table 3 shows that the lowest cost option is to maintain the current facility. 9(2)(j) [redacted] (b)(ii)

3.6.2 Indicative benefits

There are significant benefits associated with a new build. While many of them cannot be quantified as such, it is possible to provide an indication of some benefits and their value. We emphasise that this type of analysis needs to be viewed with caution and some of these benefits can only partially capture their value. For example, a reduction in sick leave is calculated based on a reduction of staff costs. However, reduction in sick leave can also be an indicator of staff satisfaction, which has a value to staff.

Table 4 Benefit categories

Benefit category	Value	Source
Consumer time savings	$26.10 per hour applied to reduced hours in facility if a reduced ALOS were achieved	van den Berg, Bernard et al (2013) "Attributing a Monetary Value to Patients' Time: A Contingent Valuation Approach" University of York, Centre for Heath Economics, CHE Research Paper 90
Health status improvement	Assessed at $4,795 for a one point improvement in mental health on a 1–100 scale	https://www.hnzc.co.nz/assets/Publications/Research/2017-wellbeing-valuation.pdf
Reduction in assaults on staff	$19,600 per assault	NZTA, Social cost of road crashes and injuries 2018 update April 2019, p5
Reduction in staff sick leave	$260 per day	Based on $60,000 salary

Table 5 shows an illustrative calculation of benefits that relate to an improved model of care. The health status improvement is conservative (i.e. 1 percentage point improvement) and a larger improvement would be targeted in terms of service performance. In addition, there are likely to be significant benefits accruing to wider whānau if there are improvements in outcomes for consumers and staff.

Table 5 Quantum of indicative benefits compared to status quo

Benefit	Rate	Illustrative quantum	Present value (30 yrs)
Consumer time savings	$26.10 per hour	1 day shorted length of stay for 100 people	$574,819
Health status improvement	$4795 per person	1 point improvement for 100 people	$6,600,237
Reduction in assaults on staff	$19,600 per assault	Reduction of 2 assaults per year	$539,581
Reduction in staff sick leave	$260 per day	Reduction of 20 days sick leave	$60,667

There is no obvious rationale for either shortlisted option to have higher quantified benefits than the other.

3.6.3 Risks

We have not undertaken a quantitative analysis of the risks. However, we note that RLB has allowed a 15 percent contingency over design and construction. RLB has also applied a cost uplift of around 15 percent due to the distance of the West Coast from a significant commercial centre.

Project risks are canvassed elsewhere in the business case. In our view, the main risks that would have a bearing on the economic case are delays in the construction schedule. A delay to the project start has the potential to result in further cost escalation.

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

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

4. Commercial case: preparing for the deal

We summarise the current context in which the West Coast mental health inpatients facility will be procured. We summarise the proposed procurement model and form of contracts including risk-sharing, as well as the procurement timeline.

4.1 What is the current context?

Excluding the Grey Base Hospital redevelopment, infrastructure investment on the West Coast is not significant. The March 2020 Infrastructure Commission infrastructure pipeline report only notes two projects on the West Coast. These are two school redevelopments, with estimated cost of $5m (Karamea Area School redevelopment) and less than $5m (Westland High School redevelopment). In recent years, non-residential construction for the West Coast has been relatively small (note table below excludes Grey Base Hospital consent in 2016 of ~$52 million).

Table 6: Non-residential construction values, West Coast 2015 to 2019

Non-residential Consent value ($)	Territorial Authority			
Year	**Buller**	**Grey**	**Westland**	**West Coast Total**
2015	$4,264,698	$13,889,282	$14,373,942	$32,527,922
2016	$5,724,364	$2,149,222	$2,893,038	$10,766,624
2017	$1,381,314	$4,330,300	$10,018,636	$15,730,250
2018	$3,789,040	$4,091,001	$9,573,159	$17,453,200
2019	$2,644,664	$7,606,000	$5,246,530	$15,497,194
Average	$3,560,816	$6,413,161	$8,421,061	$18,395,038

Source: Statistics New Zealand Infoshare, Sapere analysis

Therefore, while the mental health facility is not large in terms of the construction sector, it is large for the West Coast, with the likely cost of construction exceeding the total issued annual consents for the West Coast. This may impact on attracting local firms to consider bidding for the project. Direct market engagement has not occurred, although it is believed some local firms would have the capacity and capability to undertake the project.

In addition to local West Coast firms, other South Island based construction contractors would be expected to tender for the project. Companies with Christchurch bases are the most likely to tender, though wider South Island based firms may also be interested, especially those engaged in previously tourism focussed projects. The scale of this project is smaller than that of the Grey Base Hospital and Health Centre project, and therefore may not require a Tier 1 builder, reducing the chances of repeating the challenges seen in that project.

The scale of the project will also impact on sub-contractor capacity. Some trades are likely to be supplied locally, such as cement and carpentry. Larger trades such as mechanical and electrical may require Christchurch based firms to deliver the requirements.

The ongoing impact of COVID-19 on the construction sector is uncertain, and the unique nature of West Coast operations combined with recent construction experience at Grey Base Hospital could see lower competitive pressure on the tender. However, it is likely that the tender will be attractive to more firms in comparison to the larger Grey Base Hospital project, lowering the risk comparatively.

4.1.1 Grey Base Hospital experiences are instructive

The construction of the Grey Base Hospital is a recent example of the challenges of operating a construction project on the West Coast. While the scale of the task is substantially different, there remain key learnings to be taken from the experience.

Primarily, subcontractor issues are the most relevant. Grey Base experienced a range of issues, including low availability of key sub-contractors, lower productivity than anticipated and higher costs in securing subcontractors.

Mitigation of subcontractor risk will be critical when assessing contractor tenders. A potential mitigating action could be to ensure that contractors have evidence of their subcontractor engagement strategy, or a requirement for key subcontractors to be part of the construction bid. Further evidence of workforce planning would be desirable, including plans for travel and accommodation for non-local staff, given the potential schedule and cost implications.

In developing the estimated construction cost, the risk for increased cost from the West Coast location was included with a location loading.

4.1.2 National construction context is challenging

New Zealand is expected to see a large level of infrastructure investment over the next decade. An estimated NZ$129 billion is expected to be spent on capital projects between 2019 and 2029,[16] with the health sector making significant capital investment in facilities.

The construction industry plays a major role in New Zealand's economy, but there are skills and labour shortages, inappropriate and/or unclear risk allocations and a lack of co-ordinated leadership. There is concern that the construction sector is stretched and will not be able to meet the required growth in infrastructure. Government and the construction industry have undertaken a shared responsibility to change the way major projects are procured and delivered through developing the Construction Sector Accord, and establishing the Infrastructure Commission Te Waihanga.

Construction accord

The Construction Accord was launched in April 2019. The Accord has four goals: to increase productivity, raise capability, improve resilience, and restore confidence, pride and reputation.

[16] Forecasts from the Infometrics Infrastructure Pipeline Profile (captures non-building construction including: roading, rail, and other land transport; ports and airports; electricity generation, electricity transmission, and electricity distribution; irrigation; and local council spending on the three waters), retrieved from https://treasury.govt.nz/information-and-services/nz-economy/infrastructure

Underpinning the goals is a desire to improve the culture in the sector, which is guided by four principles: build trusting relationships, be bold, value our people and act with collective responsibility.

In developing the procurement plan, we have considered how our procurement plan aligns with the principles and goals of the Accord.

Procurement rules

The most recent Government Procurement Rules were published in October 2019. They are designed to support good market engagement, with a focus on the importance of open competition. The updates are designed to achieve wider public outcomes for New Zealand, including improving the construction industry's performance and resilience. Following the procurement rules is mandatory for construction projects greater than $9 million.

In particular, the Procurement Rules require public bodies to consider broader outcomes (social, environmental, cultural or economic) that arise as a result of procurement and delivery of a project. Specifically:

- Increase access for New Zealand businesses to procurement opportunities and encourage agencies to involve Māori, Pasifika and regional businesses as well as social enterprises.
- Suppliers expected to contribute to growth of construction skills and training, to support the expended capability and capacity of the construction workforce.
- Improving conditions for New Zealand workers, such as protecting workers from unfair and unsafe behaviour and labour practices.
- Transitioning to a net-zero emissions economy and designing waste out of the system to support a circular economy.

The broader outcomes will be reflected in the procurement strategy, tender evaluation development and during construction of the mental health facility.

COVID-19 impact is uncertain, but will be significant

Short-term impacts are considerable:

- Infrastructure New Zealand on 30 March 2020,[17] estimated the current situation could see a decline in construction company employment of 30 percent within three months, with a slow recovery over the following 12 months. The long-term effect on contractor financial health is uncertain. For example, Fletcher Building announced at the start of April a significant cut in pay for employees to cover the period of working restrictions,[18] and in May announced a redundancy programme affecting 10 percent (1000 employees) of its New Zealand staff.[19]

[17] https://infrastructure.org.nz/media/8868809
[18] https://fletcherbuilding.com/news/significant-uptake-of-fletcher-buildings-bridging-pay-programme/
[19] https://www.fletcherbuilding.com/news/fletcher-building-update-on-trading-and-organisation-reset/

- Rider Levett Bucknall reported at the end of Q1 2020 that nearly all the cranes operating in New Zealand stopped work in response to COVID-19.[20] The exceptions were essential health projects in Auckland and Christchurch.

The impact on projects are uncertain. The remote nature of the West Coast may constrain interest from national firms, though this may be tempered by a general reduction in project availability.

4.2 Preferred construction approach

There are ranges of general contracting options that may be appropriate to consider.

- **Construct only**: design is fully developed before the construction contract is awarded. The client engages consultants to prepare a design against a brief and budget, and to prepare the tender documents. Contractors are then invited to submit bids to carry out the construction work, based on the tender documents. Consultants review the contractors' bids, select and recommend the most favourable option for the client.
- **Design and construct**: this option allows the general contractor to take on the responsibility for design, as well as construction. The client develops a set of procurement requirements. The level of information provided in the client requirements depends on the complexity of the project.
- **Construction management**: the client enters in direct contracts with trade contractors and engages a construction manager to manage the trade contractors. There is no single contractual point of responsibility for trade contractors. This method breaks down a project into small packages that can be let for tender as-and-when the design for each package is complete.
- **Management contractor**: very similar to construction management, except a general contractor or construction manager enters into direct contracts with each trade contractor. This is likely to create a higher price as there are greater levels of risk for the management contractor.
- **Project alliancing**: a relationship-style arrangement that brings together the client and one or more parties to work together to deliver the project, sharing project risks and rewards. Collaborative procurement methods are typically used for highly complex or large infrastructure projects that would be difficult to effectively scope, price and deliver under a more traditional delivery.

The relative size of this project eliminates Construction Management, Management Contractor and Project Alliancing options given their relative complexity and high requirements on the principal. Therefore, Construct Only and Design and Construct are the two most appropriate contractual structures.

[20] https://www.rlb.com/en/news/2020-03-30-cranes-stop-working-across-nz-as-construction-sites-shut-down-due-to-covid-19/?geolocation=oceania

4.2.1 Clear preference for construct only

The table below sets out a discussion of the relative advantages and disadvantages of the two shortlisted contractual options.

Model	Advantages	Disadvantages
Construct only	Highest level of control and certainty regarding scope, because principal engages design consultants and scope is well defined prior to works commencing Contract value is known before construction commences because the full design is prepared and endorsed prior to tendering-design complexities are resolved before contract award Potential of lower cost of bid for tenderers and client (although design costs borne by client) Larger pool of potential tenderers, increasing competition Greater scope for competitive prices because of design certainty Client manage stakeholder management process Allows client to retain control of the design development stage, which means the requirements can be accommodated within specific designs rather than a functional specification Wider pool of design consultants	Separate design and construction contracts mean no single point of responsibility for the project Potential claims and delays due to design deficiencies, and separation of design from construction Client retains the risk of constructability of design, design construction coordination, fitness for purpose, and design generally Client acts as project manager requiring skills and resources Adversarial contract environment – potentially higher costs from claims though depends on degree of specification
Design and construct	Single point of accountability for design and construction Administrative efficiency Fast track—time saving because construction can commence ahead of full design documentation (provided there is adequate control over design quality) Contractor can contribute construction experience into the design, resulting in innovation and efficiencies Lump sum for design and construction	Early design works take place before contractor award Requires fully developed scope and quality documents to allow for accurate bids Longer bidding period needed to allow tenderers to assess design risk and delay advancement of design Principal may pay a premium to transfer design risks Lack of focus on lifecycle costs and considerations Client may be liable for time and cost overruns

Model	Advantages	Disadvantages
		Changes in scope cost more Less focus on fit for purpose solutions Greater risk due to lack of early detail that the project will not achieve its key deliverables and will not be totally fit for purpose.

WCDHB has a clear preference for a design then construct process. The relatively simple nature of the construction project increases the advantages of a construct only process.

Previous experience at Grey Base Hospital and Akaroa Health Centre in CDHB suggests cost risk is of primary concern. This is best alleviated by providing construction contractors with a fully scheduled and documented design on which to base their tender submission. This approach places design risk onto WCDHB, however this can be mitigated by clearly defined scope, experienced consultants and appropriate stakeholder engagement.

Choosing a construct only procurement plan has implications for the design element of the project. Detailed design will be procured in advance of the construction contract tender process, to allow full design to be included in the construction tender documentation.

4.3 Design and construction services are needed

A construct only procurement method will require separate contracts for construction and design, with design completed in advance of the construction process.

WCDHB will procure an architecture firm to progress the design of the mental health facility though to detailed design. The detailed design will define all building elements, materials and systems. Detailed design will feed into both the consenting and procurement of the construction contractor.

Beyond production of the detailed design, the design team will also review construction bids to ensure they meet the design requirements. Following the start of construction, the design team could also be involved in checking the construction process is meeting the specifications and performance criteria set out in the detailed design.

Stakeholder engagement is important to the design of the mental health facility. It will be important for the design team to be closely involved with ensuring stakeholders' needs are met in the design and construction of the facility. Engagement with the existing User Group will be needed, and potential design providers will need to demonstrate their experience in navigating a broad and diverse set of stakeholders.

Completion of the detailed design will inform the tender process for construction services. A main construction contractor will be engaged to build the new facility, undertake associated site works as well as demolish the existing facility.

4.4 Procurement timeline promotes efficiency

Both the design and construction contracts will be procured in an open Request for Proposal (RfP) process via the Government Electronic Tender Service (GETS). It is recommended that it is a one-step competitive tender is carried out for both the design and the construction. An open competitive tender is required given the size of the construction is greater than $9 million. This is a transparent process, provides a true indication of project costs and is aligned to Government rules of procurement. An indicative timeline for the RfPs is set out below.

The design procurement timeframe will take place following approval of this business case, and preparation of a detailed procurement plan and tender documents.

Action	Design
Approve Procurement plan	Week 0
Upload RfP to GETS	Week 1
RfP closes	Week 4
Evaluation of bids closes	Week 6
Contract negotiations complete	Week 7
Management recommendation and signoff	Week 8
Construction/design commencement	Week 9

Following the completion of design, an approximately ten month process, the one-stage RfP timeline would proceed.

Action	Construction
Approve Procurement plan	Week 0
Upload RfP to GETS	Week 1
RfP closes	Week 8
Evaluation of bids closes	Week 10
Contract negotiations complete	Week 12
Management recommendation and signoff	Week 14
Construction/design commencement	Week 16

We note that a one-stage procurement time frame will work best when there are a limited number of interested bidders. Should market conditions change and the mental health project is anticipated to attract significant bids from construction firms, then an alternative approach may be used. If a large number of bids are expected, the workload on the procurement team is substantial, and it may dissuade high quality tenders due to a lower perceived probability of success. To mitigate this, a two-stage process would be used to refine a long list of potential parties to a short list of four or five, before moving to a detailed tender request and evaluation.

4.5 Evaluation criteria and evaluation team

An appropriately qualified team will be involved in evaluating bids and recommending the preferred supplier. Selecting the right members of the panel will increase the quality of decision making for the preferred supplier. The panel make-up should ensure key stakeholder organisations and their views are represented. This will ensure the end user opinions are catered for.

People with specific knowledge of construction projects and expertise in undertaking evaluations on the scale and nature of projects similar to the facility build will be included on the panel. Care will be taken to ensure there is a diverse mix of members from different backgrounds to enable a broad suite of views are covered.

Management of the integrity of the evaluation is of critical import. It is important to consider conflict of interest across time. Experts that may have previously been in consortium with bidders, may have business relationships in the future with bidders or may be in direct competition with bidders currently, would not be permitted. Advice is also that those personnel that prepare tender documentation, those that prepare the evaluation criteria and the evaluation panel members should be kept at arm's length from potential bidders, such that no bidders are advantaged in any way.

Evaluation panel membership would consist of the following members:

- DHB project lead
- MHAS clinical representative
- Programme Director Construction & Property
- WCDHB Facilities Team
- WCDHB General Manager
- Project quantity surveyor

There will also be a set of non-voting advisors representing these specialities:

- Legal
- Financial
- Probity
- Architect

4.5.1 Prerequisites ensure minimum standards are met

To progress to tender evaluation, both design and construction bidders will need to fulfil a set of prerequisites.

- Must have a legal structure or proposed legal structure with one organisation with clear responsibility and accountability to deliver the Requirements.
- Demonstrated company is financially sound, can meet a solvency test and provide audited accounts.

- Must have prior experience in constructing or designing buildings of a construction value of a minimum of $5 million within the last five years. Previous experience on health projects will be an advantage.
- Bidders to demonstrate that they comply with all relevant employment standards and health and safety requirements.

Successful meeting of prerequisites will allow bidders to be assessed against specific criteria, which are set out below.

4.5.2 Design tender evaluation criteria

Category	Detail required	Weighting
Fixed Price	Breakdown for each design stage, and rates for variations	25%
Methodology	How design will be progressed including interaction and engagement with clinicians, user group, iwi and other stakeholders as required	25%
Experience	Previous experience in designing similar sized facilities in regional locations Performance in previous design to be assessed against price, timeframe and quality (feedback from clients and post project reviews)	25%
Capacity	Availability of key personnel and ability to deliver design in proposed timeframes	25%

4.5.3 Construction tender evaluation criteria

Category	Detail required	Weighting
Fixed Price	Breakdown for stage of construction Variation methodology and pricing	40%
Methodology	Proposed approach for delivering contract Integrated project timetable Relationship management Risk register and mitigations Site health and safety plans Opportunities for partnering with Māori and Pasifika organisations Links to local businesses Alignment with Construction Accord (social, green and broader outcomes)	20%
Experience	Previous experience in constructing similar sized facilities in regional locations Organisation capability Availability of key personnel	20%

Capacity	Sufficient resources to complete project Sub-contractor engagement Key capital equipment	20%

The proposed evaluation criteria is assumed on a single stage RfP. If as noted above, the procurement moves to a two-stage process, the evaluation criteria would also change. In the short-listing stage, construction firms would be assessed against their suitability to conduct the construction task. The second stage would be focussed on total project value basis.

4.6 Risk allocation will be fair and transparent

The WCDHB will seek a risk allocation that fairly and transparently allocates project risks between the construction industry and itself:

- The risk allocation strategy is based on the principle that risks should be held by the party that is best positioned to manage, understand and price each risk. Risks are assigned to the party who can most effectively reduce the likelihood of each risk or reduce the adverse impact of that risk should it occur.
- The approach transfers key risks—such as construction performance, cost overruns and programme—to the successful bidders.
- The DHB will retain risks with time and cost implications, as well as design risk.
- A detailed risk allocation between WCDHB and the construction contractor will be agreed during the construction contract negotiations.

The proposed key risk allocation is summarised in the table below:

Risk type and allocation	West Coast DHB	Contractor
Site Risks		
Existing ground conditions (pre-construction and construction)	✓	
Unforeseen contamination	✓	
RMA designation	✓	
Finds/archaeological artefacts	✓	
Design		
Design specification (including clinical requirements and performance standards)	✓	
Changes to design specification (including clinical requirements and performance standards)	✓	
Design constructability	✓	
Conformance with design specification	✓	
Compliance with legislative design standards	✓	

Design fault (including incomplete or ambiguous drawings) or delay	✓	
Building, engineering and resource consents	✓	
Construction		
Site safety		✓
Construction programme and performance		✓
Building inspections, and code compliance		✓
Construction cost overruns (e.g. labour supply, materials, fuel, etc.)		✓
Construction errors, defects, non-compliant works, quality control		✓
Financial		
Insurance premium increases (construction)		✓
Inflation/escalation (pre-construction)	✓	
Inflation/escalation (during construction)		✓
Exchange rate movements		✓
Sufficient capital allocated to meet scope and delivery requirements		✓

4.7 Contract rules and payment terms

4.7.1 Contract terms

For the design works contract, the WCDHB long form consultant contract (CCCS structure with WCDHB special conditions) will be used, and the standard form construction contract (NZS3910:2013) will be used as the base contract for the construction works.

The key steps are:

- a contract structure with a fair risk allocation that ensures a clear description of roles and responsibilities, process for proposing and pricing changes/variations, inclusion of termination clauses, a security regime and disputes resolution process
- a draft version of the desired contract will be issued alongside the RfP allowing the opportunity to negotiate contractual positions with the contractor and reduce contract changes during the construction phase.

4.7.2 Payment terms

WCDHB will pay a fixed price as agreed in the contracts for designing and delivering the mental health facility. The payment terms will be set as standard under the Construction Act 2002.

- Progress payments will be made according to an agreed schedule that is linked to agreed milestones. Milestones will be developed and monitored by the DHB's project team.

- Required outputs will need to be demonstrated to have been delivered within a given time period or to meet a given milestone to be eligible for payment.
- Any contractual changes or variations made to the scope, programme or performance metrics after contract signing will be incorporated into the payment mechanism once that change or variation is agreed by the DHB.
- The DHB expects payments to be subject to an agreed security regime. The regime may include liquidated damages, insurances, guarantee(s), performance bonds or retentions.

5. Financial case: affordability and funding requirements

The purpose of the financial case is to illustrate the cost of the preferred option and provide an assessment of its affordability. This proposal requires capital spending of 9(2)(b)(ii) in 2022/23 (nominal dollars). We show the operating cost and balance sheet effects of the proposal to assist with consideration of whether there is sufficient financial headroom for the proposal to proceed.

Asset related costs (being depreciation and capital charge) of 9(2)(b)(ii) will be incurred for the 10-year period from 2020/21 to 2029/30. The additional annual charge to the statement of comprehensive revenue and expense will be 9(2)(b)(ii) in asset related costs. We note that additional revenue of 9(2)(b)(ii) in the form of capital charge relief will be provided, which will reduce the net impact on the DHB's position. This net amount of 9(2)(b)(ii) represents about [redacted] of DHB expenditure.

5.1 Assumptions

This section sets out the assumptions that were used in developing the Financial Case. The general assumptions are summarised in Table 7.

Table 7 Overall assumptions

Assumption	Detail	Source
Capital charge	6% per annum assessed on depreciated cost of facility	Treasury
Capital charge relief	Assume that Government will fund capital charge component as per interim decision	https://www.beehive.govt.nz/release/extra-support-dhbs-help-costs-building-new-facilities
Completion of works and handover of asset to the DHB	30 June 2023	Modelling assumption
Depreciation	Straight line assessed at a weighted average rate of 3.7%	RLB
Capital spend will be met by the Ministry of Health	During the construction period, the Crown will release funds that match the construction cost, at the time that money is needed.	DHB assumption

A comprehensive depreciation rate was modelled using a breakdown of the square metre rate from RLB and is shown in Table 8.

Table 8 Breakdown of useful life

Element	Cost/sqm	% of total	Expected life (years)
Substructure	9(2)(b)(ii)	17%	50
Frame		1%	50
Upper floors		3%	50
Roof		7%	15
Exterior walls and exterior finish		5%	30
Windows and exterior doors		6%	30
Interior walls		11%	25
Interior doors		6%	25
Floor finishes		2%	11
Wall finishes		0%	15
Ceiling finishes		1%	25
Fittings and fixtures		3%	25
Sanitary plumbing		4%	20
Heating and ventilation services		13%	16
Fire services		3%	15
Electrical services		5%	15
Special services		9%	15
Drainage		1%	50
Weighted average			27

5.2 The 10-year cost is 9(2)(b)(ii)

Table 9 shows the required spending through to 2029/30. Total operating spending required is 9(2)(b)(ii); the net figure is 9(2)(b)(ii) when capital relief is received. The total operating spending net of capital relief will be taken into the accounts as a non-cash charge against the Statement of Comprehensive Revenue and Expense.

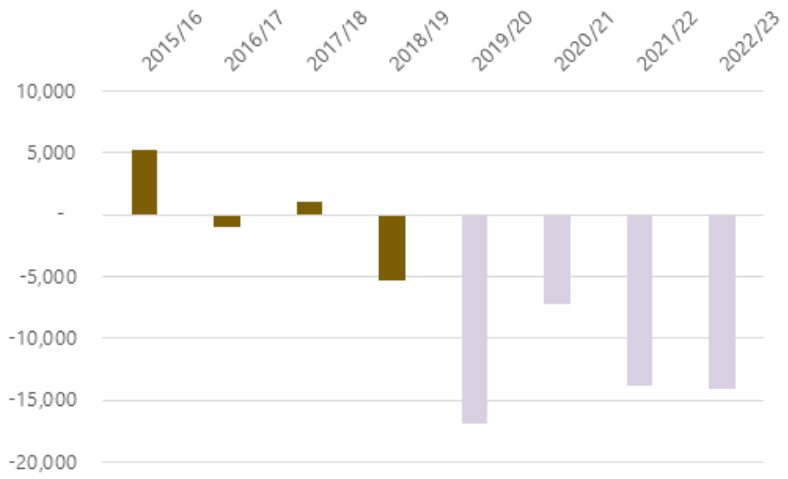
Table 9 Capital and operating spending required

	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	Total
MoH managed	9(2)(b)(ii)										
Capital investment											
DHB managed											
Depreciation											
Capital charge											
Total operating costs											
Less capital charge relief											
Net effect on DHB financial result											

5.3 The DHB suffers on-going deficits

WCDHB has limited reserves with negative working capital of 9(2)(b)(ii) at 30 June 2019. There are no investment assets. Starting from 2019/20 WCDHB will require deficit support funding to cover a negative free cash flow position, as cash reserves will have been used up.

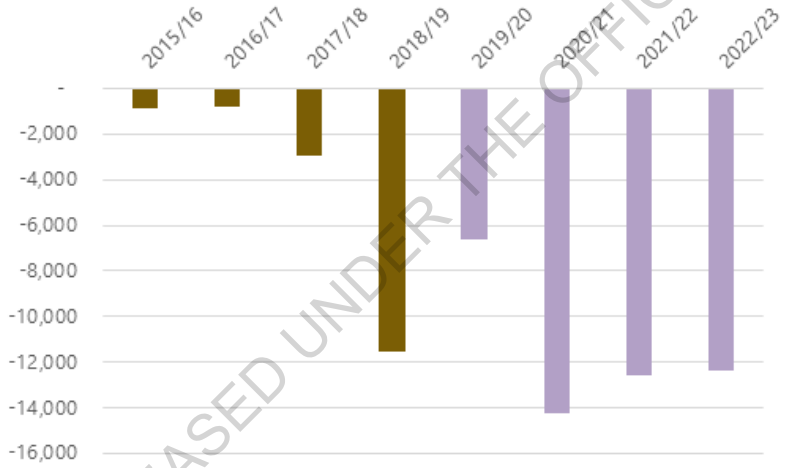
Figure 11 Free cash flow (actual and forecast) $ thousands



Source: West Coast DHB Annual Reports; Annual Plan

WCDHB recorded deficits between 2015/16 and 2018/19, although last year's result was exacerbated by one-off effects relating to a pay settlement which affected all DHBs. Figure 12 shows the actual and forecast results out to 2022/23. The DHB is forecast to require ongoing deficit support of around 9(2)(b)(ii) [redacted] per annum based on the current funding formula.

Figure 12 Net result actual and forecast - $ thousands



Source: West Coast DHB Annual Reports; Annual Plan

5.4 Financing with Crown equity

Options for financing are the following:

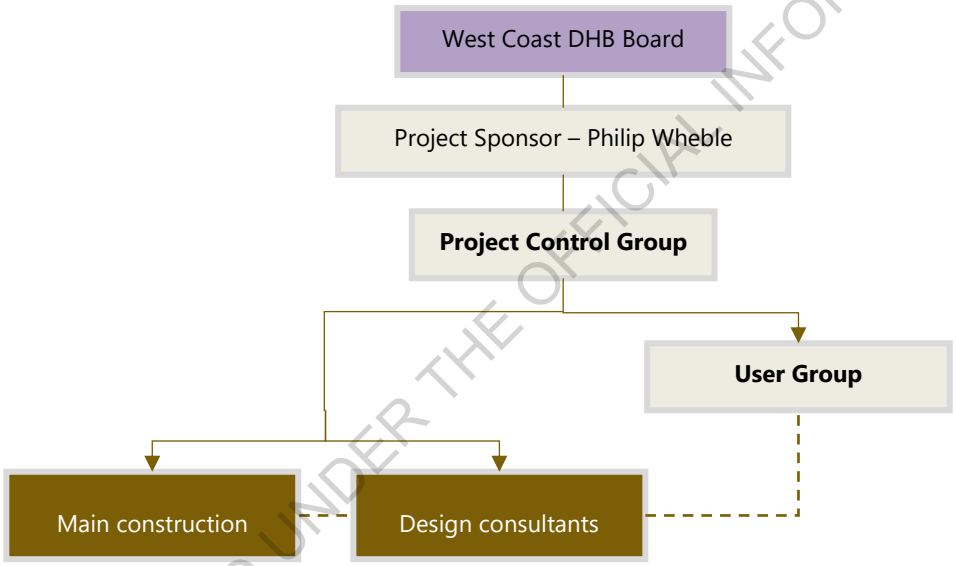
- financing from the DHB balance sheet—not possible because of insufficient funds
- public-private partnership—unrealistic because of small size of project and not possible because of Government policy
- debt—DHBs are not able to take on long term debt under current policy settings
- equity transfer from Crown—the Ministry of Health has advised that Crown financing will be available for this project.

6. Management case: planning for successful implementation

The management case confirms that the proposal is achievable and details the arrangements needed to both ensure successful delivery and to manage project risks, while maintaining a focus on delivery of benefits.

6.1 Project governance and management arrangements

The WCDHB Chief Executive has overall responsibility and accountability for the investment. Philip Wheble, General Manager West Coast, is the Project Sponsor. He is responsible for ensuring regular reporting mechanisms are established and maintained to keep the Chief Executive and WCDHB governing bodies informed of the project status. The diagram below shows the project governance and management structure.



Project Control Group

An internal governance group will be set up to oversee the project. The Project Control Group (PCG) will meet on a monthly schedule, and any issues arising between regular meetings requiring immediate attention will be escalated to the sponsor.

The PCG members will include:

- Mark Newsome, Project Director – provide overall monitoring of the project and reporting to the sponsor
- Bryan Geer, Clinical Nurse Specialist – MHAS User Group representative – to ensure User Group input is sought where appropriate
- Brent Woolhouse, Manager, Facilities Maintenance – maintenance advisory role and ensure a successful handover to business as usual

- Heather McPherson, MHAS Clinical Director – provide direct clinical advice to project
- DHB Procurement representative – manage both the procurement of the design and construction contracts, as well as ongoing contract management, variations or disputes
- Design Project Manager (in attendance only) – manage the day-to-day design works, programme and interaction with user group. Will be central contact for the design works
- Construction Project Manager (in attendance only) – manage the day-to-day building works and programme. Will be central contact for the construction works

The PCG leads the development, design and implementation of the work. They will work with the Procurement Team to procure detailed design and specialist consulting services, and a lead contractor to build the facility. The Procurement Team will lead the development of appropriate documentation to be posted on GETS.

In addition to the PCG, the WCDHB has a role of Medical Director, Facilities Development. This role will be available to provide strategic advice, direction and problem solving to the PCG as required. Where required, the DHB has other specialist advisors available to provide specific advice, for example tikanga Māori advice.

6.2 User Group will contribute to the facility design

WCDHB has recently included user groups in the development of the Grey Base Hospital & Health Centre and the Buller IFHC, and is experienced in their form and including user group input into the design process.

The User Group will report to the PCG. The existing User Group will be expanded to include a wider range of disciplines and ensure strong nursing input. The group will input into the detailed design of the building to ensure that the end result is a built environment that closely matches the needs of service users, and provides appropriate support for family/whānau. Where required the User Group will reach out for input from the community, this may be in form of consultation or secondments onto the group.

The User Group will be chaired by Heather McPherson, MHAS Clinical Director. The benefit of ongoing user group input, including to detailed design stage, is that it provides consistency of input and allows the development of ideas that better inform design throughout the project.

User Group members will be able to regularly engage with designers to take early observations and thoughts to fruition in the detailed design stage. Members will build knowledge, skills and shared experience which can add significant value to consideration of options and inevitable choices about design, materials and construction. The project will continue with extensive engagement in a user group process to incorporate co-design principles and to realise this value throughout the project.

Final design decisions will be made by the sponsor in conjunction with the PCG. The current membership of the User Group is outlined below. The current composition of the user group is weighted towards DHB representatives, and this will evolve through the design phase to include a wider range of stakeholders, including community, iwi, and consumers.

Name	Position
Brittany Jenkins	Director of Nursing WCDHB
Russ Aiton	Chair Consumer Council WCDHB
Gary Coghlan	General Manager Māori Health WCDHB
Heather McPherson	MHAS Clinical Director WCDHB
James McLean	Clinical Manager Mental Health Services Central Region WCDHB
Jane George	Director Allied Health Scientific & Technical WCDHB
Keri Page-Kreis	Senior Management Accountant CDHB
Mark Newsome	Director Facilities Development
Monique Gale	Portfolio Manager, Mental Health, Planning and Funding CDHB
Paula Mason	Clinical Nurse Manager, Manaakitanga Inpatient Unit, MHAS WCDHB
Philip Wheble	General Manager West Coast, WCDHB
Sandy McLean	Team Leader Planning & Funding Mental Health & Addictions, CDHB

6.3 Project takes time to develop design

The design and construction programme is not confirmed. The next steps following approval of this business case are to:

- confirm the project control group membership
- develop a detailed project management plan for approval by the project control group
- procure detailed design consultants.

The project has four main stages: inception, detailed design, main contractor procurement, construction. An indicative timetable for high-level key milestones is outlined below but this will be revisited in the detailed project plan. Consideration of the time for the construction will build on recent experience of the Grey Base Hospital and IFHC, and the specific workforce challenges experienced. While uncertain, the chance of inclement weather during the early stages of construction may impact project schedule given the higher than average level of rainfall on the West Coast.

Stage	Stage	Duration	Start date	End date
Inception	Confirm project governance structure and membership	1 month	Month 1	Month 1
	Procure design consultants	8 weeks	Month 1	Month 2
Design	Preliminary design	10 weeks	Month 3	Month 5
	Developed design	16 weeks	Month 5	Month 8
	Detailed design (Drawings for consent/tender/construction)	18 weeks	Month 9	Month 13
Contractor procurement (see commercial case for further detail)		4 Months	Month 14	Month 17
Construction	Consenting and construction period	16 months	Month 18	Month 33
	Complete build and handover	2 months	Month 34	Month 35

The project will follow a work programme owned by the Project Director, working closely with the Construction Project Manager. Any changes to the project's capital requirements or risk mitigations will be considered in accordance with the delegated financial authority policy and risk management policy.

The Construction Project Manager will provide the following at least each month to the PCG:

- Project schedule – monitoring
- Project status report – in the format of the standard Clinical Support Services report template
- Project financials including reporting commitments and use of contingency
- Project risk updates – the project will be run to the ISO:31000 standard

Other items will be provided as directed by the PCG or at appropriate stages of the project.

6.4 Change management is part of wider DHB changes

WCDHB has undertaken significant change planning during the construction of Grey Base Hospital and IFHC. This experience will be carried forward into the construction of the mental health unit.

Recently, an organisation restructure brought the MHAS into the integrated locality health services. To continue on the journey, the culture must develop further, with mental health as part of a joint focus on physical and mental health. Previously mental health was separate and did not engage with physical health. The new facility will be a component of the required changes.

Mental health and addiction services will evolve to being delivered in local communities, with the inpatient unit to support community provision, and to provide support without disconnecting consumers from their family/whānau. An associated part of the change in mental health provision is a move to a rural generalist model, where non-traditional roles are used to provide mental health support. The roles could include nurses, nurse practitioners and the allied health specialities. Early intervention can be achieved by moving to a greater focus in provision from primary care.

6.4.1 Communications will be specific to the audience's needs

A detailed communications plan will be developed following approval of the business case. The strategic communications advisor will be engaged to develop the plan using their experience of communicating in the trans-alpine community space.

Engaging with internal and external stakeholders in the development of the new mental health facility is paramount. The communications approach will ensure that the flow of information is two way and allows feedback from stakeholders rather than simply presenting information without engagement. Central to the communications will be a repository hosted on the DHB website that contains all publicly released information including media releases, project plans and available design information. The communications schedule will be driven by specific project events, with content driven by new information.

The User Group will be the primary method to communicate to close stakeholders. This channel is important to create engagement with our diverse stakeholders and will continue through the project.

We will engage and keep MHAS staff informed, beyond the user group process, as they will be critically impacted by the new facility. A feedback mechanism will be developed to gather staff input throughout the project. Regular DHB communications will be used to share project updates with the wider WCDHB community.

The mental health and addictions community, which includes users, whānau and supporters, are the primary external audience. The user group is an important source of information and members will be encouraged to share information at an appropriate level, with their wider networks. We will provide regular updates to the West Coast Consumer Council as the project progresses. Information will be disseminated to the general public through mainstream and social media. We will consider whether one or more community forums are needed.

6.5 Benefits management will be core to the project

The WCDHB's experience in benefits planning has been informed by the recent Grey Base Hospital and IFHC. The benefits committed to in those projects have been largely realised ahead of the completion of the build.

Benefits management is the identification, analysis, planning, realisation and reporting of benefits. Project investment decisions need clearly defined deliverables and measurable benefits. WCDHB will manage the benefits in four stages:

1. Identification: Identify benefits, dis-benefits, measures and benefit owners
2. Analysis: Quantify and analyse the benefits and how the benefits will be measured
3. Planning: Defining when benefits are expected to occur, and what is needed to be done to achieve the benefits
4. Realisation and Reporting: Track and report on benefit occurrence. This will take place during and after the project

The expected benefits have been initially identified in the Strategic and Economic Cases. Project benefits will be managed during and after the project, with appropriate monitoring and reporting. The Project Sponsor will be responsible for managing the benefits process and will be accountable for the benefit realisation. To manage the benefit realisation, benefit documentation process will include:

- Benefit Profile: benefit details
- Benefits Realisation Plan: benefits and when they will be achieved
- Benefits Register: a consolidated view of benefit information.

6.6 Risk management is mature and project risks are developing

A risk schedule for the project will be managed by the Project Director. The Project Director will manage the project policies and practices for the identification, assessment, recording, treatment,

mitigation, monitoring and reporting of all risks and issues, which have the potential to threaten the project schedule, budget or quality of deliverables or have an adverse impact on the DHB.

Risks and issues will be a standard agenda item at PCG meetings and will form part of projecting reporting to the sponsor. Key risks (i.e. those that have changed significantly or require urgent attention) will be reviewed by the Project Sponsor.

The detailed project risk schedule will also be informed by the risk registers developed by main contractor. It will be contractually required to identify, monitor and manage risks relating to the project where necessary and reasonably practical.

Ultimate ownership of risks will sit with the Project Sponsor, who will delegate day-to-day management of individual risks to the appropriate person or group. Where applicable, project risks will be escalated as part of the DHB risk management process through the Quality, Finance, Audit and Risk Committee.

6.6.1 Risk scoring matrix/DHB overall risk approach

Risk evaluation will be consistent with the overall WCDHB process, which is governed by the Quality, Finance, Audit and Risk Committee. Risks will be assessed based on likelihood and consequence, using the existing DHB framework. We present the framework below:

Risk consequence	Examples
Serious	• Death(s) or permanent disability of staff/contractor or visitor related to work incident or suicide • Cessation of a key service • Extended Ministerial Inquiry • Cost overrun or reduction in revenue > $2m or 2% of total divisional expenditure budget
Major	• Major injury/illness to staff/contractor or visitor • Significant ongoing disruption to a key service • Major inquiry by external agency • Cost overrun or reduction in revenue > $1m or 1% of total divisional expenditure budget
Moderate	• Disruption to a key service • Inquiry by external agency • CEO intervention • Cost overrun or reduction in revenue > $100k or 0.1% of total divisional expenditure budget. (whichever is lesser)
Minor	• Medical treatment or injury/illness for 2 or more staff/contractor or visitors • Disruption to a service • Cost overrun or reduction in revenue > $50k or 0.05% of total divisional expenditure budget. (whichever is lesser)
Minimal	• Minimal injury to any person(s), first aid required, with no lost time or restricted duties for staff/contractor • Service delivery substandard • Cost overrun or reduction in revenue > $10k or 0.01% of total divisional expenditure budget. (whichever is lesser)

Likelihood of risk occurring	Definition
Almost Certain	Is almost certain to occur within the foreseeable future or within three months
Likely	Is likely to occur within the foreseeable future or in the next four to twelve months
Moderate	May occur in the foreseeable future or in the next one to two years
Unlikely	Is not likely to occur within the foreseeable future or in the next two to five years
Rare	Will only occur in exceptional circumstances

Combination of the consequence and likelihood estimates create a risk score from the matrix below. The most critical risks are those that are rated High or Extreme.

Risk Matrix		Consequence				
		Minimal	Minor	Moderate	Major	Severe
Likelihood	Almost Certain	Low	Medium	High	Extreme	Extreme
	Likely	Low	Medium	High	High	Extreme
	Moderate	Low	Medium	Medium	High	High
	Unlikely	Low	Low	Medium	Medium	High
	Rare	Low	Low	Low	Low	Medium

6.6.2 Preliminary risk register

The table below outlines initial significant risks identified at this stage in the project and associated mitigation strategies. A full risk management plan will be developed by the Project Director as part of the project inception phase and will be endorsed by the Project Sponsor. The current risk register is yet to reviewed by the Quality, Finance, Audit and Risk Committee.

Risk	Consequence	Likelihood	Risk level	Mitigation
Tight construction market may mean it is difficult to engage an appropriate main contractor.	Severe	Likely		Engage main contractor as early as possible. Consider appropriate agile procurement process to reduce time.
Unexpected costs or cost escalation may result in the need to request additional funding to complete the project.	Severe	Likely		Costs to be validated by an external quantity surveyor. Appoint experienced Construction Project Manager. Regular reporting on budget.

Risk	Consequence	Likelihood	Risk level	Mitigation
Delay in construction works impacts overall timeline.	Likely	Moderate		Incorporate lessons learnt from Grey hospital build in developing schedule Monitor schedule closely and escalate early if any concerns. Regular monitoring at site meeting and oversight at Project Control Group.
Changes in scope of project, or changes to design of facility after construction commences increases project costs	Major	Moderate		Early and frequent engagement with user group to deliver an agreed design Close management of user expectations Clear project governance and accountabilities to limit post final design changes
Poor integration of contractors may lead to design issues that result in financial and administration issues.	Major	Moderate		An appropriate procurement model for selection of experienced contractors and consultants. External advice with regular meetings.
Discrepancies, design errors in consultants' documentation could lead to quality and financial administration issues.	Major	Moderate		QA checking of all documentation. Ensure skilled and experienced consultants are engaged. Regular communication, design meetings, with consultants/contractors to work as a close team.
The completed building not fit-for-purpose or does not meet users' needs.	Severe	Unlikely		User Group process has close engagement with the design team through preliminary and developed design. Close engagement of Facilities Management with the Facility Project Team.
West Coast location limits availability of staff and resources	Major	Likely		QS to apply lessons learned from recent West Coast construction experience to cover cost implications Construction timeframes to be tested with main contractor bids taking into account potential resource constraints
Model of care not being implemented in a timely way or project delays implementation of changes in model of care	Major	Moderate		Coordination between project governance and DHB governance to ensure model of care changes progress with project programme Engage those delivering model of care
Sustainable staffing model unable to be delivered due to mismatch of workforce skills	Severe	Unlikely		Inform wider DHB governance of the expected benefits that rely on a suitable workforce Recruitment focus on future facility workforce requirements rather than on current needs

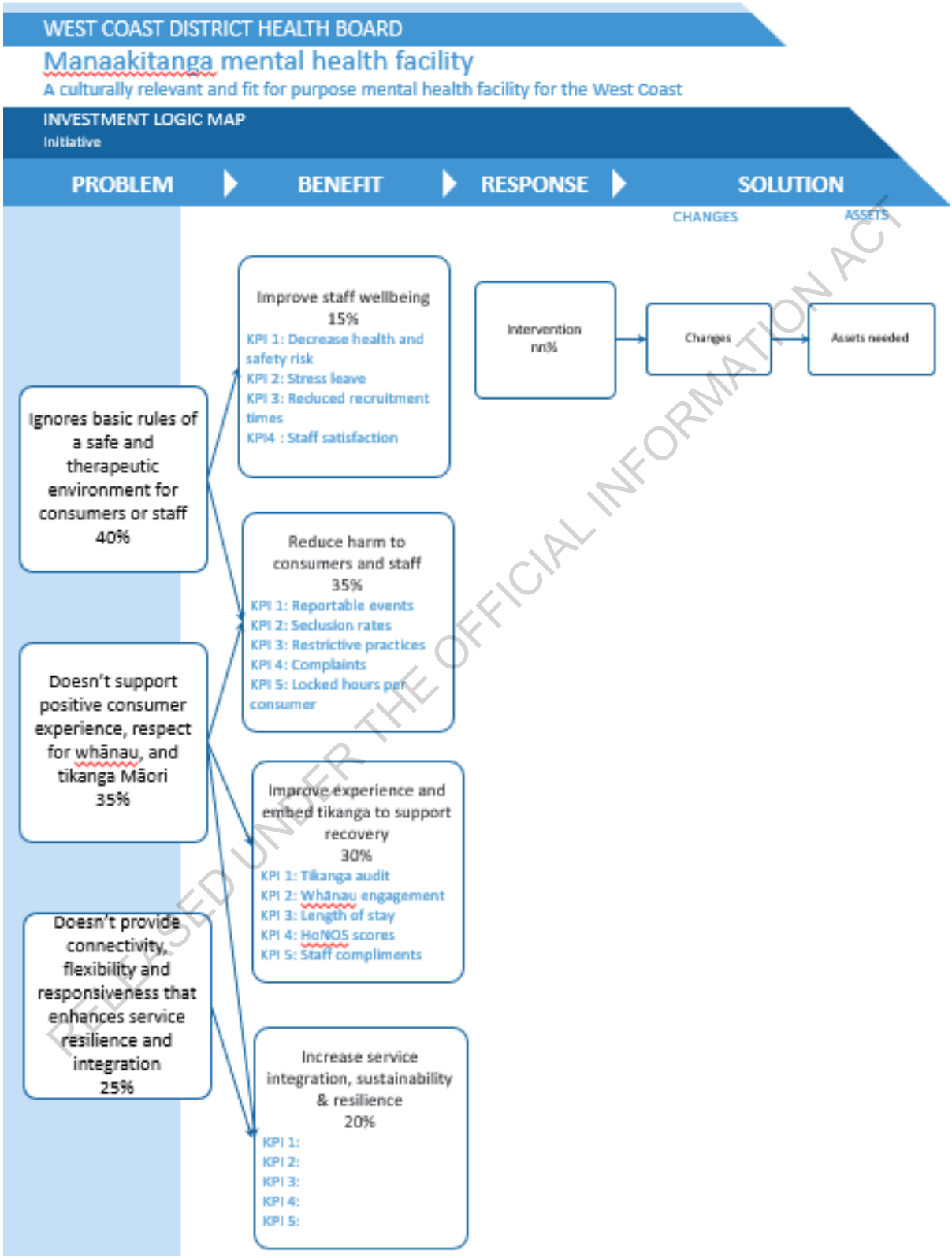
6.7 Project reviews will be independent

WCDHB will commission independent auditors to undertake a set of reviews before, during and after the project. They will report to the Quality, Finance, Audit and Risk Committee. The planned reviews are:

- Pre-project—set planned audit process, review and implement information capture required for assessments at mid and post-project stages
- Mid-project—track ongoing project performance against timeline and budget. Consider effectiveness of governance process and stakeholder satisfaction
- Immediate post-project—identify lessons learned and to assist in planning of future, similar projects. Consider project performance by tracking project performance against original timeline and budget
- Post-project—post-implementation review to assess if expected project benefits were achieved

9(2)(j)

Appendix A Investment Logic Map



9(2)(j)

[redacted]

Appendix C Refurbishment versus new build comparison

Table 10 Comparison of refurbishment and new build options

Criteria	New build	Refurbishment
Functionality (by zone)		
Whole building	Scope: New custom designed building to suit Model of Care and meet all design principles.	Scope: Staged full refurbishment of existing building including removal of cladding, fenestration, roofing, internal partitions, and services. Strip to concrete frame and re-build new in stages while maintaining operation of service. Refurbishment within building footprint with some external space additions to meet design principles where possible.
Front of house	Planning Benefits Opportunity to provide culturally appropriate point of arrival which is welcoming and provides dedicated point of entry from the street. The whānau, arrival and family spaces are maintained in the front of house zone with good daylight access. Whānau spaces are not integrated within the inpatient accommodation zone, enabling privacy to be maintained for consumers.	Action - Full strip out and Refurbishment - The whānau, arrival and family spaces are reconfigured in the front of house zone. Planning Benefits Whānau spaces are not integrated within the inpatient accommodation zone, enabling privacy to be maintained for consumers. Planning Issues Service Entrance into front of House Zone requires crossover of activities. Privacy Issues Pedestrian access from Hospital from North makes secure entry in view and less private.
Consumer accommodation **Daily living zone** **Therapy zone**	Planning Benefits All new single rooms with ensuites configured in pods, each with sea view and immediate access to recreational and activity spaces distributed around internal courtyard areas.	Action - Full strip out and Refurbishment of existing workspace to provide single rooms configured in pods. Planning Benefits All new single rooms with ensuites each with sea view and immediate access to recreational and activity spaces.

		Construction Limitations Extensive plumbing work required to enable ensuites to be provided with bedrooms. Planning Limitations Existing stairwell location restricts bedroom placement and pod arrangement. External Space Limitation Limited ability to provide external access from proposed consumer living zone. New Platform required for external area reduces usability of lower ground north facing spaces. No separate external area for vulnerable cohort. Privacy Issues High Needs Daily Living overlooking IPU courtyard area restricting size of courtyard. Workspace and staff amenities in client zone – occupant privacy issue. Stair location causes crossover of flows in IPU to reach downstairs spaces. Security Issues Daily living areas at dead ends and not visible – increased safety risk. Clinical support with limited visibility of IPU activities.
'Flex accommodation'	Planning Benefits Ability to swing beds between low dependency and high dependency and/or provide for separation of vulnerable cohorts is provided with access to dedicated recreational areas.	Planning Benefits Ability to use two bed low needs pod for vulnerable cohorts with dedicated access to recreational and courtyard areas. Planning Limitations Poor ability to flex low needs beds for high needs. High needs pod adjacent to 4 bed low needs pod.
High needs accommodation **High needs daily living zone**	Planning Benefits Two single rooms with ensuites configured with immediate access to dedicated high needs recreational and	Action - Full strip out and Refurbishment of existing workspace to provide for high needs accommodation. Planning Benefits

	activity spaces distributed around internal courtyard areas	Ability to provide external access from proposed high needs living zone Close connection to clinical support areas Planning Limitations No circulation loop through to low needs inpatient zone, requires travel through high needs areas or workspace / staff amenities zone.
Assessment zone	Planning Benefits Privacy, safety and security established from a discreet point of vehicle entry directly into the Assessment zone.	Planning Benefits Security established from a discreet point of vehicle entry directly into the Assessment zone. Planning Limitations The constraints of the location impact on the general amenity and the extent to which privacy and culturally appropriate care can be supported. Privacy Issues Relocation of secure entry zone provides entry north of but adjacent to front of house – limiting ability to achieve privacy and discretion for arrivals in distress. Security Issues Secure Zone at dead end risks staff safety
Low stimulus zone	Planning Benefits One low stimulus room with dedicated retreat courtyard access. The low stimulus zone is offers ease of access for consumers from either the high needs or low needs accommodation or on arrival to the unit via the secure entry.	Action - Full strip out and Refurbishment of existing front of house and workspace to provide for low stimulus accommodation. Relocation of low stimulus zone provided adjacent to high needs zone and secure assessment zone. Planning Benefits One low stimulus room with dedicated retreat courtyard access. Planning Limitations Poor access to and from low needs zone impacting on ability to discreetly move consumers in times of agitation. Consumers moving from secure zone to low needs inpatient zone are required to travel through front of house zone compromising privacy.

		Security Issues Distance of clinical support to secure zone increases staff response time. Secure Zone at dead end risks staff safety
Clinical support	Planning Benefits Centralised clinical support designed to enable sharing of resources across both high needs and low needs zones.	Action - Full strip out and Refurbishment to a consolidated centralised clinical support zone. Planning Limitations Distance of clinical support to secure zone reduces staff sharing efficiencies across both high needs and low needs zones
Staff resources	Planning Benefits The new build provides accommodation for all community teams alongside inpatient unit staff which enables the transition of consumers in and out of the unit to be better coordinated by the teams which work across the continuum of care. Dedicated community workspace zones achieved distinctly separate to inpatient environment.	Action - Full strip out and Refurbishment of inpatient areas to include workspace for MHAS and Inpatient staff. Planning Benefits Relocation of workspace with capacity for all community teams to be accommodated. Planning Issues: Workspace provided at lower level with access via stairwell in low needs inpatient zone. Privacy Issues A portion of community team workspace provided within the inpatient zone has potential to negatively impact the consumer experience.
Tribunal zone	Planning Benefits Tribunal / meeting room with support spaces provided with immediate access to the front of house zone.	Planning Benefits Tribunal / meeting room with support spaces provided with immediate access to the front of house zone.
External areas	Planning Benefits The new build concept design provides consumers with access to a variety of	Action – New building platform for external walled courtyards for IPU and Low stimulus zones. Repurposing and adaption of existing balcony space for High needs courtyard. Planning Limitations

	external spaces by way of internal courtyards within the low needs, high needs, and low stimulus areas.	No existing internal courtyards. New internal courtyard provision not feasible in a staged refurbishment option which maintains service. Existing architecture limits the opportunity to provide for other external space for service user, family / whānau to access. New space provision north of building compromises internal living space and has limited connectivity to clinical support and daily living areas. Architectural issues Visual impact of courtyard fencing and walls to image of mental health provision. Reduced light and views to lower ground Limited views for high needs accommodation.
Connectivity with campus physical health activity	Planning Benefits The concept design places the unit in the 'village' of Te Nikau and the IHFC. Transfers from ED or IFHC may walk with direct pathway access or be transferred by vehicle.	Site Limitations Unit will be isolated from physical health activities in Te Nikau and IFHC. Transfers from ED or IFHC likely to require transfer by vehicle. Management of staffing between IFHC and Unit needed and consideration of increased transfer durations.
AHFG alignment	Planning Benefits AHFG recommends 32% circulation for inpatient area, not acknowledging specialist nature of mental health cohort. CD Option A provides 44% circulation acknowledging requirements for whānau inclusion and advancing models of care in a small acute mental health facility.	Planning Limitations Refurb provides 34% circulation for inpatient area. Meets AHFG but does not acknowledge requirements for inclusion of whānau or advancing acute mental health models of care. Circulation resources are provided in the wrong place with too much provided in secure zone and front of house.
Functionality – whole of building		

Cultural Appropriateness	Planning Benefits Inclusion of a number of internal and external spaces which may incorporate features to support cultural identity and promote placemaking.	Planning Limitations The constraints of the location of the secure entry impact on the general amenity and the extent to which privacy and culturally appropriate care can be supported.
Capacity	Planning Benefits The concept offers 8 beds with ability to expand in increments which will maintain functionality and connection with the planned unit.	Planning Benefits The refurbishment provides for 8 beds and adequate workspace for community teams. Planning Limitations Poor future flexibility to expand bed provision and maintain flows and connections in line with contemporary models of care.
Flexibility	Planning Benefits The concept design offers ability to swing beds for vulnerable or high needs cohorts	Planning Benefits Refurbishment achieves a two bed pod providing flexible use for vulnerable cohorts. Planning Limitations Poor ability to flex for high needs cohorts.
Adaptability	Planning Benefits The concept offers a high level of adaptability with the building form able to support alternate functions over time. Ability to repurpose workspace for outpatient activities. Activation of the area for use as outpatient activity would result in the displacement of staff workspace but could be considered in the longer term as a strategy which again	Planning Benefits The existing footprint and the available expansion zone limit the ability to yield a higher number of beds over time.

	would not result in disruption to the inpatient unit during fit out.	
Project delivery		
Buildability	Action: The concept site is adjacent to the escarpment and transitional cottages on the main route to Te Nikau and IFHC, An option (A) straddling the escarpment requires retaining and earthworks to provide part two storey facility connecting to the hospital at upper ground for public and lower ground for servicing. An option (B) by the escarpment requires earthworks and rerouting of the main access road to provide flat siting for a single level new build. Buildability Benefits Either option can be constructed without disruption to existing hospital activities. Single stage construction reduces build complexity and timeframes.	Action: Roof replacement required HVAC upgrade/replacement required Full cladding and glazing replacement required Full fitout replacement required Buildability Issues Complex to maintain building services during multiple stages. Staged decommissioning of plant – increased service risk during changes. Construction will have impacts on cost and program. Service Issues Potential Impact on consumer experience during construction: noise, vibration, views and amenity. Potential impact on consumer wellbeing during construction: consumer security and safety to be considered. Potential impact on staff wellbeing including maintenance of safety and security. Clinical, service, and public flows are disrupted during construction with limited ability to separate flows for low and high needs zones.
Expandability	Planning Benefits Ability to expand building to the south and retain good internal functional zone relationships.	Planning Benefits Site limitations: existing buildings and infrastructure limit expansion options.

Programme and staging	Programme Benefits New build on greenfield site	Programme and Service Issues Staged refurbishment required. Existing community team workspace requires relocation during refurbishment with potential impact on staff experience due to displacement. Workflow impact: community team collaboration with inpatient services for coordination of consumer care and discharge planning challenged due to displacement during construction.
Risks		
Infrastructure	The design of a new build MHIPU shall impact upon the infrastructure services. Further whole of site investigations are required to take place. The building services requirements for the new MHIPU have been indicated as achievable and shall be investigated during the next design phase. (Refer Opus High Level Description 08/03/2020)	Degree of upgrade to existing services (capacity) and impact on compliance (upgrade to current codes) requires full up to date assessment.
Site	Discovery of latent conditions not identified during existing conditions surveys during this Concept Design phase. e.g. in-ground conditions.	The refurbishment / expansion option makes several assumptions with regards to the extent that existing infrastructure can be extended, or 'plugged into' . If the existing infrastructure proves to not have this capacity or capability, there is risk the services may be more difficult and/or expensive to achieve.
Model of care	Support services model including delivery of food, management of waste and linen provided via a separate non-public flow.	Support services model including delivery of food, management of waste and linen continue to be provided via front of house zone and crossing public flows.

9(2)(j)

NEW MENTAL HEALTH FACILITY BUSINESS CASE

West Coast – District Health Board –
Te Poari Hauora a Rohe o Tai Poutini

TO: **Chair and Members**
West Coast District Health Board

SOURCE: **Facilities**

DATE: **26 June 2020**

Report Status – For:	Decision ☑	Noting ☐	Information ☐

1. ORIGIN OF THE REPORT

This paper is intended to provide the Board information with regard to the new Mental Health Facility business case to enable them to make a decision on the options presented to proceed to submitting the business case to the Capital Investment Committee for their 24 July meeting (deadline 3 July).

2. RECOMMENDATION

That the Board:

i. Endorses that an Inpatient Mental Health facility must be provided on the West Coast
ii. Notes the WCDHB Mental Health Facility Functional Design Brief
iii. Notes the Concept Plans, Site Options and Architectural Drawings
iv. 9(2)(j) [redacted]
v. Endorses the Replacement of the Mental Health Facility at Grey Base Hospital, Single Stage Business Case
vi. Endorses the submission of the business case to the Capital Investment Committee seeking approval for 9(2)(b)(ii), 9(2)(j) [redacted].

3. DISCUSSION

The current Mental Health facility is old, in disrepair and not fit for purpose, and does not support a contemporary model of care for the delivery of mental health. In addition, the facility compromises the basic rules of a safe and therapeutic environment for consumers and staff; does not support positive consumer experience, respect for whānau, and tikanga Māori; and does not provide connectivity, flexibility and responsiveness that enhances service resilience and integration.

In 2019 the Ministry of Health reviewed the Grey Mental Health facility in two streams:

- Clinical Facility Fitness for Purpose (CFFFP) and
- Building & Infrastructure

These results were published in the 'National Asset Management Programme for district health boards: Report 1: The current-state assessement' (June, 2020).

The CFFFP assessment rated the facility using nine principles, with a total possible score of 275. The Grey Mental Health facility scored 118, giving it an 'average' rating.

Campus	Unit	Principle # 1 Appropriate *external* functional relationships	Principle # 2 Appropriate *internal* functional relationships	Principle # 3 Access	Principle # 4 Adequately sized / shape / layout key clinical spaces	Principle # 5 Enhance communication between staff and patients	Principle # 6 Enhance privacy	Principle # 7 Reduce patient infections	Principle # 8 Reduce medication errors	Principle # 9 Enhance staff & patient safety	Principle Total
Greymouth	MHIPU	14	11	1	21	16	5	15	3	32	118
	Total Possible Score	20	30	15	55	30	5	35	20	65	275

The building and infrastructure assessment rated the West Coast District Health Board Mental Health building the worst at 'Very Poor' with regard to the condition score, and was the worst of all mental health units assessed nationally (19).

The redevelopment of the Grey Mental Health facility has always been tied to the Te Nikau Grey Hospital and Health Centre development, with a separate business case to be developed. The development of the business case has been delayed until now due to Mental Health services being reviewed in 2013. This was followed by extensive work in implementing the model of care, which is ongoing, and further delayed by the impacts of the Te Nikau Grey Hospital and Health Centre development being delivered 2 and half years late.

The attached papers, and the presentation to the Board summarises the process to date to arrive at the Functional Design Brief, Concept Plans, Site Options, Business Case and high-level costings. Clinicians and consumer representatives, have been involved in User Groups meetings to develop the attached briefs and options. In addition, there has been Canterbury DHB clinical input. Further, local iwi has been updated and an agreement reached for iwi involvement in the project once funding is approved.

At a high level, the development of a new Mental Health facility is expected to deliver the following benefits: -

- Improved recovery / wellness outcomes
- Improved consumer experience and participation and embedding of tikanga Māori
- Increased service integration, sustainability, resilience
- Reduced harm to consumers
- Reduced harm to staff
- Improved staff wellbeing
- More rapid return to work or leisure

The Mental Health user group considered a number of options, including refurbishment of the current facility. 9(2)(j) [redacted]

9(2)(j) [redacted]

6. APPENDICES

Appendix 1: *WCDHB Mental Health Facility Functional Design Brief*
Replacement of the Mental Health Facility at Grey Base Hospital, Single Stage Business Case
WCDHB MHIPU – Drawing Set
Ministry of Health correspondence re Health Infrastructure Package.

Report prepared by: Mark Newsome

Report approved for release by: Philip Wheble, General Manager
David Meates, Chief Executive

West Coast District Health Board

Te Poari Hauora a Rohe o Tai Poutini

Corporate Office
High Street, Greymouth

Telephone: 9(2)(a)
e-mail: 9(2)(a)

1 July 2020

9(2)(a)
Chair
Capital Investment Committee

Dear

Mental Health Facility Business Case West Coast

At our meeting on Friday, 26 June 2020 the West Coast DHB Board approved the following in relation to Mental Health facilities in Greymouth and directed that this now be formally submitted to the Capital Investment Committee:

That the Board

i. Endorses that an Inpatient Mental Health facility must be provided on the West Coast
ii. Notes the WCDHB Mental Health Facility Functional Design Brief
iii. Notes the Concept Plans, Site Options and Architectural Drawings
iv. 9(2)(b)(ii), 9(2)(j)
v. Endorses the Replacement of the Mental Health Facility at Grey Base Hospital, Single Stage Business Case
vi. Endorses the submission of the business case to the Capital Investment Committee seeking approval for 9(2)(b)(ii)

The Board noted the 2019 Ministry of Health review of the Grey Mental Health facility and the results which were published in the 'National Asset Management Programme for DHBs: Report 1: The current state assessment' (June, 2020). The building and infrastructure assessment rated the West Coast District Health Board Mental Health building the worst at 'Very Poor' with regard to the condition score, and was the worst of all mental health units assessed nationally (19).

9(2)(j)

The Board looks forward to receiving support from the Capital Investment Committee for this critical facility.

Please do not hesitate to contact me should you require any further information.

Kind Regards

Hon Rick Barker
Chair, West Coast District Health Board

Copy to: 9(2)(a), Director-General, MOH
9(2)(a), DDG DHB Performance Support & Infrastructure, MOH

P.O. Box 387, Greymouth

[redacted]

From: Kay Jenkins
Sent: Wednesday, 20 January 2021 12:56 PM
To: Mark Newsome
Subject: WC Mental Health
Attachments: 1012 - Letter to Chair CIC from Chairman re Mental Health 2020-07-01.pdf; 1012 - app Item 2 - Board PX - 26 June 2020 - APPENDIX 1 Mental Health Business Case.pdf; 1012 app Item 2 - Board PX - 26 June 2020 - APPENDIX 2 Mental Health Business Case.pdf; 1012 app Item 2 - Board PX - 26 June 2020 - APPENDIX 3 Mental Health Business Case.pdf; 1012 Appendix Item 2 - Board PX - 26 June 2020 - Mental Health Business Case.pdf

Not sure if you have these?

It was sent while I was away.

Cheers
Kay

[redacted]

From: [redacted]health.govt.nz>
Sent: Friday, 12 February 2021 4:53 PM
To: Rick Barker; Andrew Brant; Peter Bramley; Philip Wheble; Kay Jenkins
Cc: [redacted]; Mark Newsome
Subject: RE: Mental Health Facility, Greymouth

Follow Up Flag: Follow up
Flag Status: Completed

Hello Rick,

Thanks for your time earlier today to discuss this.

As outlined, we have initiated active support with the DHB to progress the Business Case. As you note below, the current impasse needs to be addressed with a clear pathway forward.

Our Health Infrastructure Unit (HIU) Programme Director, [redacted], will lead our engagement to support the DHB team in progressing a revised Business Case. We understand that the respective DHB contact for this is Mark Newsome. Our teams met on site last week to review the current facility and work to date.

I have also discussed this briefly with Peter and Andrew last week, outlining the approach for this project to be supported under our Mental Health Infrastructure Programme (MHIP). This provides closer alignment and efficiencies for the planning, design, and delivery of Mental Health facilities nationally.

In the first instance, the HIU and DHB team are developing a proposed approach and clear timeline to deliver the revised Business Case. I expect that this is put up for review and agreement jointly by the DHB and HIU in two weeks (26/02).

I noted and support your comment that the DHB Board must have clear visibility and support of the approach and timeline to progress this.

I trust this aligns with your understanding of our discussion. Do please give me a call any time if this raises further concerns or questions.

Regards,

[redacted]
Director, Health Infrastructure – Delivery
DHB Performance, Support & Infrastructure
[redacted]
http://www.health.govt.nz

From: Rick Barker [redacted]
Sent: Wednesday, 10 February 2021 10:50 am
To: [redacted]@health.govt.nz>; Andrew Brant <Andrew.Brant@cdhb.health.nz>; Peter Bramley <Peter.Bramley@cdhb.health.nz>; Philip Wheble <philip.wheble@wcdhb.health.nz>; Kay Jenkins <Kay.Jenkins@cdhb.health.nz>
Subject: Mental Health Facility, Greymouth

Hello [redacted]

The mental health facility is rated by the MoH advisors as at the bottom of the list.for least satisfactory facilities. The case for an upgrade is well made.

The WCDHB submitted a business case for a new facility to best integrate into the new Te Nikau facility on the basis that the existing facility had such issues with earthquake strengthening and suitability that a refurbish rebuild was not practicable.

MoH responded with a set sum allocation for the refurbishment a figure well below a rebuild. There was no explanation as to how this would work.

In a chance discussion with [redacted] Chair CIC he indicated that he believed a clear path to make the MoH funding work. Unfortunately there was no time for an explanation of how this would work.

This issue needs to be resolved. There are outstanding earthquake issues. The building is by any cursory inspection below the standards seen as acceptable today. Allowing this matter to drag on is unacceptable.

Resolving this will be a fraught process if it is by exchanges of correspondence such as we have hard to date. I am very keen to reach an agreement on the pathway forward. I am committed to finding a pathway in a timely manner

To this end I have proposed a meeting in Greymouth with key people to inspect the premises to ensure we all see the same things, to review the background paperwork on earthquake risk, suitability of premises ensuring they are fit for purpose now and in the future, and following this hopefully agreement on a pathway forward for a timely replacement or refurbishment.

I look forward to your reply

Regards

Rick
Chair
WCDHB

--
Hon Rick Barker
[redacted]

From: 9(2)(a) rcp.co.nz>
Sent: Thursday, 18 February 2021 8:37 AM
To: 9(2)(a) Mark Newsome
Subject: Grey Mental business case timeline[EXTERNAL SENDER]

Follow Up Flag: Flag for follow up
Flag Status: Completed

Hi Mark and 9(2)(a)

Following up from our phone please see below suggested timeline for the Grey mental health business case update:

Key activity	Duration	Start	Finish
Engage consultant for revised DSA and condition assessment. Consultant to be confirmed.		22 February	
Prepare DSA and condition assessment. Consultant to be confirmed.	6 weeks	22 February	1 April
Investigate a 9(2)(j) rebuild option (CCM)	6 weeks	22 February	1 April
Develop a revised refurbishment option (CCM)	6 weeks	22 February	1 April
Review needs analysis in Business case with DHB stakeholders (Sapere)	2 weeks	22 February	8 March
Review Model of Care/ Clinical services plan with MOH/Mental health directorate	4 weeks	8 March	1 April
Prepare business case report based on above options and problem definition (Sapere)	4 weeks	6 April	6 May
DHB/MOH review of business case report	2 weeks	6 May	20 May

Let me know if you have any further comments and I can tidy it up this for reporting.

Regards

9(2)(a)
Project Manager
9(2)(a)

[redacted]

From: [redacted]ccm.co.nz>
Sent: Thursday, 4 March 2021 7:15 AM
To: Mark Newsome
Subject: Grey AMHU: Draft Programme[EXTERNAL SENDER]
Attachments: Grey AMHU - Draft Programme.pdf

Follow Up Flag: Flag for follow up
Flag Status: Flagged

Hi Mark,

Please find attached draft programme ahead of our call this afternoon.

Our internal conversation has been about the relationship between plan development with users, and MoC. It strikes us that with a refurbishment or [redacted] option the key questions will be less about the facility layout than the impact those constraints on the MoC. So we are suggesting that in the first instance we work up those scenarios on our own (blind) so that we have something to test with the users. The user discussion is to socialise those plans and to explore what they would mean for MoC (noting that it may well be a challenging discussion, so framing the exercise correctly will be very important). Once that discussion has been had, we suspect that there may be a third option that comes up to be explored a bit.

I'll call you as early as I can this afternoon when I get out of my user-group meeting [redacted]

Cheers,
[redacted]
Director

CCM Architects

[redacted]
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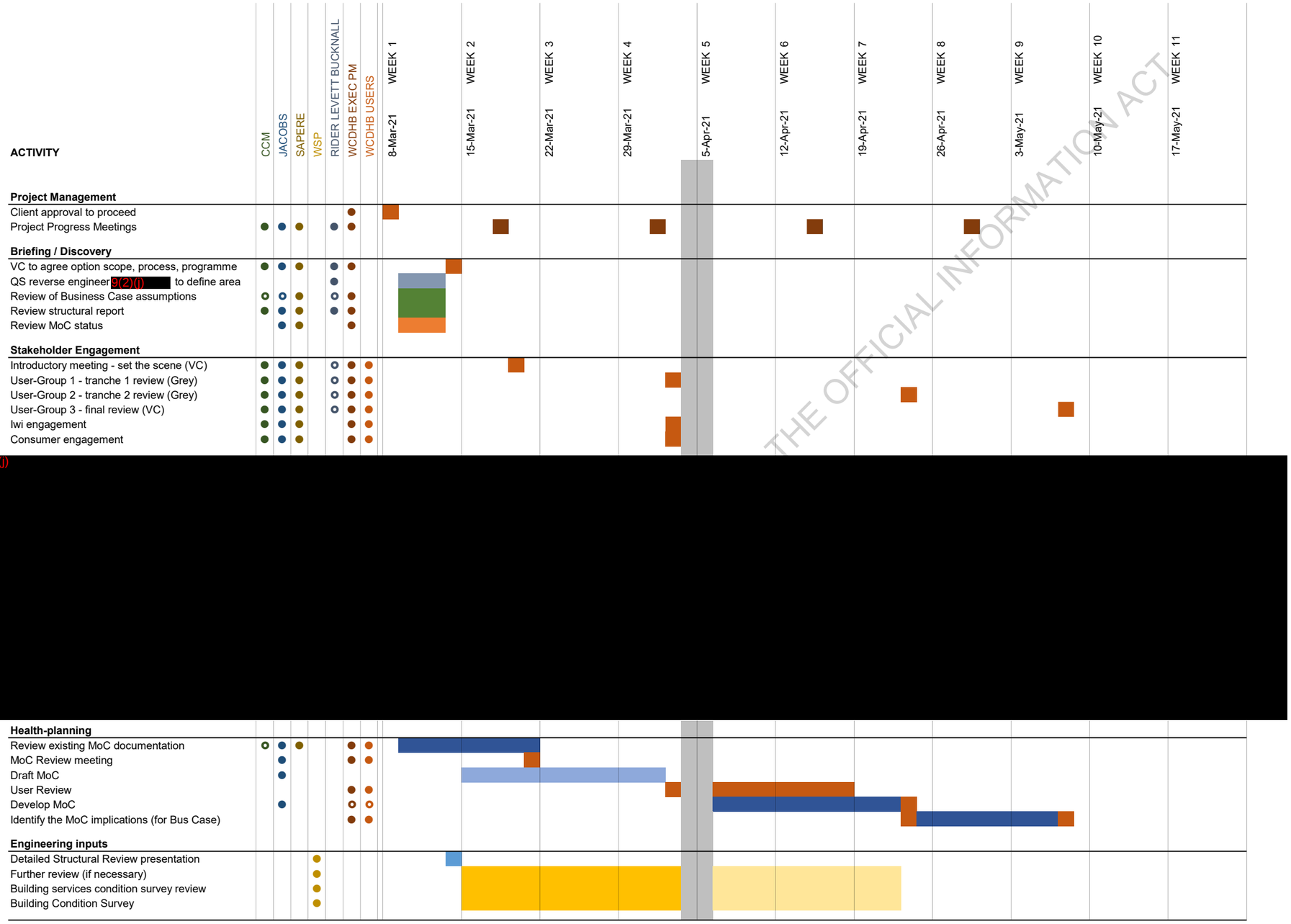
WCDHB AMHU: BUSINESS CASE REVIEW

CCM ARCHITECTS
INDICATIVE PROGRAMME | RESOURCE | FEE SCHEDULE
03 | 03 | 2021 REV.2 (Draft Proposal)



[redacted]

From: 9(2)(a) [redacted]
Sent: Tuesday, 13 April 2021 8:45 PM
To: Mark Newsome
Subject: WCDHB Mental Health Facility Business Case Revision Costs
Attachments: WCDHB Mental Health Business Case Revision Funding Approval -1.docx

Follow Up Flag: Flag for follow up
Flag Status: Flagged

Hi Mark,

Apologies as it is now beyond close of business and again the paper is late. I know there was considerable pressure on you to have this request submitted today.

However, I hope this paper is inclusive of all details required to approve funding.

I could not find a RLB QS estimate for this work so thus the delay and late in the day have ended up with 9(2)(b)(ii) [redacted] for RLB as the costs will need to be completed for a refurbishment in detail, any outputs from Aurecon (for example plant replacement) and CCM including exploration of a 9(2)(b)(ii) [redacted] option.

I was tempted to state ….'submission to CIC of a revised business case will arguably act to mitigate any impact the recent seismic report findings and initial costs proposed may have on the project's prioritisation of centrally allocated health capital funding ' but thought it maybe too direct.

If this paper needs to be amended please let me know.

9(2)(a) [redacted]

West Coast Health
BUILDING A BETTER FUTURE

West Coast DHB | Mental Health Facility | Business Case Development	
Date: 20 April 2021	**Purpose: For Approval**

Purpose

This paper seeks approval of DHB funds required for work to be undertaken to revise the Business Case for the proposed new West Coast District Health Board [WCDHB] Mental Health Facility development.

Background

The WCDHB board approved the Mental Health Services Facility redevelopment Business Case on the 26th June 2020 and the business case was submitted to the Capital Investment Committee [CIC] for assessment.

Subsequently, additional information received by the DHB requires further exploration of the Business Case shortlisted options and a revised approach to the Business Case data analysis and modelling. Specifically, a second WSP engineering assessment of the existing mental health building was procured and the report indicates the building's seismic risk profile has decreased, contradicting the original WSP 2012 assessment. Furthermore, discussions with the Ministry of Health and high level feedback from the CIC indicated the proposed new Mental Health Facility Business Case requires strengthening of the strategic approach to problem definition and solutions , as well as, project scale.

Scope of Work

In order to articulate a strengthened strategic approach in a revision of the Business Case and thus better inform problems, benefits, outcomes and constraints, further work is required in terms of data collection, modelling and analysis. It is proposed the existing consultants are contracted with the addition of a variation to their existing contract, with the exception of Aurecon, who do not have an existing contract with the DHB. In this instance the DHB is needing to procure an alternative engineering consultancy due to the conflicting WSP assessment reports. The following summarises the scope of work required:

1. Seismic and Building Services -Aurecon
   - Detailed Structural Assessment [DSA]
   - Building and Building Systems Condition Assessment

2. Health Planning and Architectural Survives-CCM/Jacobs
   - Model of Care review and development
   - User group and key stakeholder re-engagement, including iwi engagement
   - Development of shortlisted options including existing building refurbishment, $15 M option and other as process evolves
   - Incorporation of engineering reviews into analysis

3. Business Case Revision- Sapere
   - Revisit strategic approach
   - Shortlisted options analysis
   - Revise financial case
   - Revise Draft business case

4. Quantity Surveyor-RLB
   - Cost shortlisted options including refurbishment and $15M option
   - Cost outputs as required from the Building Condition Report and DSA

Business Case Development Costs

The estimated funding required to revise and further develop the Business Case has been arrived at from the following fee estimates:

Table1. Consultant Fee Estimates and Timel

Consultant Works	9(2)(b)(ii)	Fee (exc.GST)	Estimated TimeLine
Engineering - Aurecon			
Detailed Seismic Assessment			
Building Condition Assessment			
Total			10 weeks
Architecture- CCM			
CCM Architects			
Jacobs			
Disbursements			
Total			11 weeks
Business Case Revision-Sapere			
80 hrs			
Contingency			
Total			80 hours
Quantity Surveyor RLB			
Inform costing of options			
Total Costs			

Business Case Development TimeLine

The timeframe to complete the work is estimated to be 3 months based on an 11 week programme of work required by CCM to complete the architecture and health planning work. Should approval to proceed be granted and contracts amended and signed within April, 2021, the revised Business Case would be ready for DHB endorsement the last week of July. Pending endorsement of the revised Business Case at the WCDHB Board meet on the 6th August, 2021 the revised Business Case will be ready to submit to CIC in mid-August 2021.

Table 2. Estimated Project Milestone Completion Dates

Milestone	Estimated Completion Date
Consultant Contracts	29th April 2021
User Group Re-Engagement	20th May 2021
Revised Draft Business Case	20th July 2021
Board Endorsement	6th August 2021
CIC Submission	August 2021

Summary

Approval is sought in this paper for DHB funding for additional work to be undertaken to revise the Business Case for the proposed new WCDHB Mental Health Facility development. The proposed revision of the Business Case will include further development of shortlisted options, model of care and associated financial analysis and will revisit the strategic approach. The consultant works required to inform the revision include procuring a third detailed engineering assessment of the existing mental health building in order to provide clarity moving forward on the two previous WSP reports which outline conflicting seismic risk profiles. The consultant costs to complete the work required to inform the Business Case are estimated to be 9(2)(b)(ii) and the programme of works is estimated to take approximately 3 months to complete.

Recommendations

It is recommended the delegated authority:

1. **Endorse** the project to proceed with the revision of the WCDHB Mental Health Facility Business Case;
2. **Approve** funds totalling 9(2)(b)(ii) to complete consultant works required to inform the Business Case;
3. **Note** the timeline milestones and estimated Business Case completion date.