Budget Sensitive

Office of the Minister of Health

Cabinet Expenditure Committee

Nelson Hospital Redevelopment: Detailed Business Case

Proposal

1 This paper seeks your approval of a Detailed Business Case (DBC) for the Nelson Hospital Redevelopment (Nelson Hospital) Project 2: Inpatient and acute services and seismic improvements, as outlined in **Appendix A**.

Relation to government priorities

2 The proposed investment is aligned with the "Achieving the Health Targets – High Level Implementation Plan July 2024 – June 2027" announced on 12 September 2024.

Executive Summary

3 This paper seeks Cabinet approval of the Detailed Business Case (DBC) for the Nelson Hospital Redevelopment – Project 2, which focuses on inpatient and acute services, alongside seismic improvements. The investment aligns with four of the five Government Health Targets, including faster cancer treatment, shorter stays in emergency departments, shorter wait times for First Specialist Appointments (FSAs), and shorter wait times for elective treatment.

4 Nelson Hospital serves 169,700 people, with critical infrastructure failing to meet seismic and clinical standards. A shortfall of 16 surgical beds is projected to rise to 53 beds by 2043, limiting admissions and increasing clinical risks. Outdated hospital buildings, some over 50 years old, are inefficient and lack modern digital capability. The hospital currently has 151 overnight inpatient beds, and on completion, will have 192 overnight inpatient beds (128 of which are in the new ward block).

5 In July 2023, Cabinet approved a Programme Business Case (PBC), allocating $73 million for Project 1 (design, enabling works, and emergency seismic upgrades) [SWC-23-MIN-0088 refers]. The original redevelopment plan involved a single Acute Services Building (ASB) at $1.098 billion, but this was deemed too large, costly, and misaligned with demand projections.

6 The revised plan (s 9(2)(b)(ii), s 9(2)(f)(iv)) proposes a phased approach, delivering a new five-storey inpatient unit, Energy Centre, and seismic upgrades while refurbishing existing buildings. This approach reduces cost, delivers benefits sooner, and better aligns with contractor market capacity. s 9(2)(b)(ii), s 9(2)(f)(iv) , the P85 cost estimate for Project 2 is s 9(2)(b)(ii) , with funding approval sought through the Budget 2025 process.

7 While this DBC is submitted earlier in the design cycle than usual (before the updated PBC), this is required to meet Budget 2025 timelines. Health NZ's new infrastructure

delivery approach using standardised components for constructing facilities and robust design controls enables benchmark costs in the DBC to provide confidence and a P85 estimate. The updated PBC will be provided to Cabinet in mid-2025 once more certainty for Phase 3 is known.

Background (Strategic case)

Strategic case for Nelson Hospital Redevelopment

8 Nelson Hospital, along with Wairau Hospital in Blenheim, serves 169,700 people across 22,700 square kilometres. The region faces significant challenges, particularly at Nelson Hospital, due to ageing healthcare infrastructure and growing demand. Nelson Hospital currently has a shortfall of 16 surgical beds, projected to rise to 53 beds by 2043. Limited capacity delays patient admissions from the emergency department, while reliance on external buildings increases clinical risks and inefficiencies.

9 Critical hospital buildings have poor seismic resilience and compromise Health NZ's ability to deliver care in a disaster. In 2020, Nelson City Council issued Earthquake-prone Building Notices (EPBNs) for four key structures, including two main clinical buildings - George Manson and Percy Brunette, requiring remediation or evacuation by 2028.

10 Compounding the seismic risks, Nelson Hospital's core clinical buildings are over 50 years old and fail to meet modern design standards. Outdated room layouts, ward sizes, corridors, and digital infrastructure hinder best practice, leading to extended stays and surgery delays or cancellations. Low telehealth capability further strains capacity and increases costs.

Previous decisions and prioritisation

11 In July 2023, Cabinet approved a PBC for the Nelson Hospital Redevelopment and released $73 million from the Health Capital Envelope (HCE) to commence Project 1 - design, enabling works, and development of a DBC for Project 2. A change in scope for Project 1 is currently being sought to realign with the proposed changes outlined in this Cabinet paper, while remaining within the originally approved budget envelope and delivery timeframe [HNZ00076452 refers].

12 The PBC responded to Cabinet's request for clarity on redevelopment needs. Initially considered as a single project, the scale and complexity of the redevelopment required a phased approach, with an estimated $1.098 billion investment over 15-years. This has since been revised to align with Health NZ's new hospital development strategy.

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

Development of the Detailed Business Case

14 The revised redevelopment programme for Nelson Hospital consists of three projects:

- Project One – Design, enabling works, and emergency seismic upgrades (funding already allocated)
- Project Two – The subject of this DBC – **Appendix A** (funding sought in Budget 2025)
- Project Three – Further seismic remediation (to be confirmed in the updated PBC (mid-2025), with costs refined as design progresses).

15 The following considerations were made in the revised redevelopment programme, resulting in significantly less cost primarily due to the removal of a new acute services building (ASB) from the current investment proposal and instead future proofing the site to enable this investment to occur at a latest date:

- Demand modelling was initially based on a 2038 population projection but has since been updated using Health NZ's standardised methodology, extending out to 2043 for greater accuracy. Revised modelling indicates no need for service expansion within a new ASB, except for additional medical and surgical beds, which are the focus of this DBC. A new Inpatient Unit is planned to address capacity shortfalls and accommodate relocated wards from the George Manson Building, which is no longer fit for purpose.
- Existing ICU, cardiology, theatres, and radiology facilities meet projected capacity.[1] The emergency department's expansion, funded separately from baseline depreciation funding ($10.9 million) eliminates the need for the previously planned large ASB. In addition, optimising existing buildings avoids full construction of a new Seismic Importance Level (IL) 4 acute and inpatients services facility. Instead, seismic upgrades will target 67% of New Building Standards (NBS) at IL4, improving service continuity in a seismic event.
- Health NZ identified inpatient general medical and surgical beds as critical for improving hospital flow and meeting acute and planned care demand. Therefore, the redevelopment prioritises a new inpatient unit, an Energy Centre to replace aged infrastructure and provide resilience, and refurbishment of outdated facilities. After constructing the new Inpatient Building and relocating wards, the George Manson and Percy Brunette Buildings will be refurbished and reduced to IL2. These buildings will be repurposed for administration, education, and ambulatory services.

16 The Programme Steering Group and Senior Responsible Officer (SRO) have endorsed the DBC and Option 5 for submission as part of Budget 2025.

17 The digital component of Project Two, s 9(2)(b)(ii) , has also been reviewed and agreed upon by Health NZ's Executive Leadership Team, ensuring delivery without reliance on national programmes while enhancing the hospital's digital capabilities.

[1] Functional capacity table – Demand modelling to 2043

Analysis (Economic case)

18 Five options were evaluated alongside the 2023 PBC agreed option, narrowing to two final options, noting the 2023 PBC agreed option was assessed against updated programme and cost estimates (see **Appendix A**):

Option	Description
1	**2023 PBC Agreed Option $1.83 billion (reassessed cost)** 9-storey Acute Services Building consolidating all acute and inpatient services, easing seismic upgrades of existing buildings. Estimated **10–12 years** to complete.
5	**New Preferred Option (Option 5 in DBC)** s 9(2)(b)(ii), s 9(2)(f)(iv) Phased approach prioritising right-sized facilities. Includes a 5-storey inpatient unit, Energy Centre, existing building refurbishments, seismic strengthening. Estimated **5–6 years** to complete.

Option 1 – 2023 PBC Agreed Option ($1.83 billion reassessed cost)

19 Option 1, the previously preferred option, provides more capacity than demand projections require, and acute services and inpatient beds in an IL4 building for seismic resilience. The revised cost estimate for this option is $1.83 billion.

20 This option enables refurbishment of existing buildings with minimal disruption but exceeds forecasted need for ICU, theatres, radiology, and some maternity/paediatric services and is therefore not supported by Health NZ from an operational expenditure and resourcing perspective.

21 This option faces major delivery risks. Large, complex projects in regional settings (e.g., Christchurch and New Dunedin) have proven challenging and limited contractor capacity in Nelson could extend timelines to **10+ years**. An enabling works review also identified design inefficiencies, prompting development of a faster, more scalable alternative that would appeal to local contractor markets.

Option 5 – New Preferred Option s 9(2)(f)(iv), s 9(2)(b)(ii) *(Recommended)*

22 Option 5 aligns with Health NZ's national demand model to 2043, has the lowest cost, and delivers benefits sooner. This option includes a ward block with 128 beds (41 of which are expansion); an acute assessment unit; a transit lounge; assessment, treatment and rehabilitation services (AT&R); a mortuary; and back of house services. The option also includes an Energy Centre and refurbishment of the George Manson and Percy Brunette Buildings.

23 The ward block will house a total of 128 overnight adult inpatient beds, including 103 overnight adult medical-surgical beds. Of these, 41 beds represent expansion – being additional overnight medical-surgical inpatient beds beyond what is currently available. The remaining beds in the new facility replace existing capacity, meaning they are relocated from the current facilities to the new ward block.

24 At project completion, there will be a total of 133 medical-surgical overnight inpatient beds across the campus, with 103 in the new ward block and 30 remaining in the

existing facility. This addresses the majority of the total bed demand deficit to 2042/43, which is projected to be 137 overnight inpatient medical-surgical beds.

25 While this results in four fewer beds than forecast demand, this variance is due to the way modelling translates into health planning units, such as adult inpatient wards. Health planners typically design wards in units of 28 or 32 beds for operational efficiency. As a result, projected demand does not always align exactly with the final design, leading to minor variations. Given that this forecast extends over a 20-year horizon, the total of 133 medical-surgical beds has been deemed sufficient. A new ASB is not included in this investment stage; instead, existing acute services will remain in their current locations. s 9(2)(f)(iv)

26 Nelson has a history of model of care interventions to reduce pressure on the hospital system. The city has the lowest numbers of acute bed days on a per capital basis. This performance has been driven by short length of stay, low percentage of long stay patients, low percentage of long stay bed days and high usage of health pathways. Further changes to models of care to address capacity issues include new and expanded models of care in the community and home settings; a staged implementation of 50% of AT&R beds over the 20 year horizon, and virtual care/hospital in the home modelled with a staged implementation of 15% of relative low acuity bed day activity over the 20 year period. See Section 3.2.2 of the Detailed Business Case in **Appendix 1**.

27 s 9(2)(f)(iv) . This phasing ensures flexibility and reduces the level of investment sought now. We will provide further advice regarding Project 3 in the PBC to be provided in mid-2025.

28 This option presents more disruption challenges than Option 1. Acute facilities will reach 67% NBS at IL4, meaning recovery times after a seismic event will be hours to days, compared to minutes in a new IL4 facility. Contingency plans for delivery of services are in place for events, prior to buildings being strengthened.

29 The viability of this option has been market-tested through Southbase and Naylor Love, both of whom are delivering comparable scale facilities for Health NZ in the South Island and confirmed the feasibility of phased delivery.

30 s 9(2)(f)(iv), s 9(2)(b)(ii) . Of this, the Project Two element of the Preferred Option has a capital cost of s 9(2)(b)(ii) covering:

- A new inpatient building and refurbishment of the George Manson and Percy Brunette buildings.
- An Energy Centre with critical hospital infrastructure.
- A digital component (s 9(2)(b)(ii)) to provide a standardised digital capable hospital (not fully digital smart) supporting improved care models.

31 Multi-criteria assessment favoured this option over a full cost-benefit analysis due to the challenge of monetising key health benefits. A cost-benefit analysis was therefore

not completed. Option 5 balances cost, feasibility, and service improvement while minimising delivery risk (as detailed in **Appendix A**).

Financial implications (Financial case)

32 The estimated capital cost for Project 2 under the preferred option is s 9(2)(b)(ii) Health NZ commissioned AECOM to prepare DBC financial costings using multiple estimation methods, incorporating allowances for the region's location. The DBC was among the first to apply Health NZ's IIG Cost Estimating Guidelines.

33 The Cost Estimating Guidelines were developed through collaboration with independent Quantity Surveying practices and draw upon the Infrastructure and Projects Authority's Cost Estimating Guidance from the UK Government. These guidelines define the cost estimation process, outline roles and responsibilities, and emphasise the importance of planning and validation alongside project inputs. They set clear expectations for the calculation, allocation, and reporting of capital cost estimates, ensuring consistency and transparency in financial planning for health infrastructure projects.

34 Early contractor reports provided insights into market capacity and delivery timelines, enabling accurate cost and escalation forecasting by a quantity surveyor. A Quantitative Risk Assessment (QRA) identified programme risks, applying Health NZ's Cost Estimating Guideline to establish contingency and escalation levels.

35 The P85 cost estimate s 9(2)(b)(ii) (**Appendix A**) reflects an 85% confidence level that the final cost will not exceed this amount. This figure is used for the Management Reserve. Operating costs, including staffing and facility operations, are not part of this business case and will be covered by baseline funding and future cost pressure allocations.

s 9(2)(b)(ii)

s 9(2)(b)(ii)

36 The Treasury Gateway team reviewed the DBC for the Nelson Hospital Redevelopment Programme and provided an Amber delivery confidence rating. Treasury recommended an updated PBC (mid-2025) to provide a holistic campus redevelopment view, followed by an Implementation Business Case (IBC) for Project Two, a recommendation supported by the Ministry of Health.

Implementation (Commercial and Management Cases)

37 Procurement will follow Health NZ's *Building Hospitals Better* approach of applying standardisation and consistency across the Regional Hospitals Redevelopment Programme, with a panel of contractors being selected for IIG major project delivery. A Design and Build delivery model with Early Contractor Involvement (ECI) will minimise design and construction risks by incorporating contractor insights early to prevent rework and delays. The project is integrated, with clinical and digital workstreams embedded in the delivery team to ensure efficient modern healthcare infrastructure and technology.

38 ECI procurement will take place in 2025, using a Health NZ Pre-Construction Services Agreement Contract with a panel of qualified contractors. The Contractor

[2] Health NZ will explore the potential of market-led proposals to build a carparking solution. This may result in the funds for the carpark building being returned to the Crown. This is part of an ongoing exploration of using private equity to build and manage hospital carparks.

panel shall be in place by the start of Preliminary Design, mid 2025. s 9(2)(b)(ii) [redacted]

39 The project will be delivered in five phases from 2026 to 2031, ensuring minimal disruption to Nelson Hospital operations and healthcare services.

Table 2: *Key delivery milestones*

Construction phases	Start	Finish
Civil works s 9(2)(b)(ii)	2026	2026
Inpatient building project s 9(2)(b)(ii)	2026	2029
Energy centre and critical infrastructure s 9(2)(b)(ii)	2026	Mid 2029
George Manson and Percy Brunette Buildings refurbishment s 9(2)(b)(ii)	2029	2030
Kitchen refurbishment s 9(2)(b)(ii)	2029	2030

40 Programme and project governance structures are well-established, with clinical representation at all levels. The Programme and Project Director has extensive experience in hospital infrastructure, including Christchurch's acute services building.

41 Health NZ's IIG Investment and Delivery Framework will guide Project Two, ensuring alignment with other hospital redevelopments for efficiency and continuous improvement.

42 Key delivery risks with a 'high' rating and mitigations are set out in Table 3 below.

Table 3: *Key delivery risks and mitigations*

Risk	Description	Rating	Comments / Mitigation
Clinical and operating requirements	Funding constraints focus on cost, rather than clinical and/or ongoing operational requirements, reducing the ability to realise clinical and efficiency benefits	High	• Programme changes have been prepared in partnership with clinical leadership, to confirm that clinical requirements can be met • Programme uses a staged redevelopment approach to ensure operational continuity
Primary care readiness	Primary care is not appropriately organised and/or does not have the capacity to respond to and deliver planned Model of Care changes meaning the facility is unable to meet the needs of the population	High	• Primary care is included in the Change Management Plan, early engagement and consultation with primary care stakeholders. • The wider regional networks are developing and will require close attention to monitor dependencies and risk
Digital readiness	Nationalisation of digital applications such as Electronic Medical Records (EMR) does not occur, leading to delays in implementation of digital solutions in Nelson hospital	High	• Develop a contingency plan to account for potential changes and delays • Provide project resources as standalone or coupled with other RHEP projects and NDH for leveraging design collateral.

Risk	Description	Rating	Comments / Mitigation
			• Establish clear communication channels and agree dependencies with national digital stakeholders

43 Health NZ's Benefits Management Plan will track outcomes against projections. A Cabinet report will be submitted 12 months post-implementation to compare actual vs. planned benefits. The Treasury will receive periodic updates on benefit realisation.

Investment assurance

44 A Gateway review of the hybrid DBC for Project 2 and the revised PBC in September 2024 recommended further development of a revised PBC for the programme.

45 The DBC for the revised construction stage was incomplete at the time of the scheduled Gateway Review. The review team acknowledged Health NZ's commitment to a new approach for the Nelson Hospital redevelopment and advised progressing a revised PBC.

46 A Gateway Review was held in September 2024 and followed by an action plan review at the end of October. This received an amber confidence rating.

Cost-of-living Implications

47 This paper has no direct cost of living implications.

Legislative Implications

48 There are no legislative implications arising from the proposals in this paper.

Impact Analysis

Climate Implications of Policy Assessment

49 The decrease of greenhouse gas emissions is not a key policy objective for the Nelson Hospital project; however, the Energy Centre will optimise operations and likely result in a reduction of emissions.

Population Implications

50 The project addresses hospital capacity needs until 2043 considering population growth, diversity, and ageing-related health complexities.

Human Rights

51 There are no human rights implications arising from the proposals in this paper.

Use of external Resources

52 Nelson Hospital is a large, complex infrastructure project. Health NZ has a core programme team and will procure external experts for technical delivery. External

business case writers and quantity surveyors provided external resource to complete the DBC.

Consultation

53 The Treasury, the Ministry of Health (the Ministry) and the Infrastructure Commission have been consulted on this paper.

Communications

54 Should the Nelson Hospital proposal be invited to the Budget 2025 process, communication of the project will be completed through that process.

Proactive Release

55 Should the Nelson Hospital proposal be invited to Budget 2025, I would anticipate delaying Proactive Release until after the completion of that process.

Next steps

56 If Cabinet approves the DBC, and pending funding commitments in Budget 2025, a revised PBC will be prepared mid-2025 to update and provide detail on Project Three. The finalised scope and updated costings for the DBC (through a quantity surveyor estimate and QRA based on at least preliminary design) will be submitted in late 2025.

57 An IBC for Project 2 will be submitted in Q2 2026. s 9(2)(b)(ii)

58 If Budget 2025 funding is not approved, Health NZ will complete emergency seismic works, enabling works and design within the scope of Project One and the original $73 million appropriation.

59 s 9(2)(f)(iv)

Recommendations

The Minister of Health recommends that the Committee:

1 **Note** that in July 2023, Cabinet approved the PBC preferred option, proposing a large single Acute Services Building and refurbishment of existing buildings, with an estimated cost of $1.098 billion, later reassessed at $1.83 billion, across nine projects.

2 **Note** that a revised PBC is under development, shifting to a staged build approach, reducing costs from $1.83 billion to s 9(2)(f)(iv), s 9(2)(b)(ii), and delivering benefits two years earlier.

3 **Approve in principle** the attached Detailed Business Case (Appendix A), which aligns with the revised Programme Business Case.

4 **Approve** the preferred option for Project 2 of the Nelson Hospital Redevelopment**,** at a capital cost of s 9(2)(b)(ii) , subject to Budget 2025 funding decisions.

5 **Note** that if the Nelson Hospital project proceeds, I will seek approval for a revised Programme Business Case in mid-2025 to update and provide detail on Project Three; a finalised scope and updated costings for the Detailed Business Case (through a quantity surveyor estimate and QRA based on at least preliminary design) in late-2025; and an Implementation Business Case for Project 2 in Q2 2026.

6 **Direct** Health New Zealand to address any concerns raised by the Treasury in relation to the Implementation Business Case.

Authorised for lodgement.

Hon Simeon Brown

Minister of Health