

Disability Support Services



**MINISTRY OF SOCIAL
DEVELOPMENT**
TE MANATŪ WHAKAHIATO ORA

High and Complex Framework

Programme Business Case

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Glossary

Table 1: Glossary

Term	Definition
Care Plan	Care and Rehabilitation Plan
CBA	Cost Benefit Analysis
CFFFP Report	Clinical Facilities Fitness for Purpose Report
CID	Crown Infrastructure Delivery
CP(MIP)	Criminal Procedure (Mentally Impaired Persons) Act 2003
CSF	Critical Success Factor
DBC	Detailed Business Case
DSS	Disability Support Services
FCS(ID)	Forensic Coordination Service, Intellectual Disability
FM	Facilities Management
HCF	High and Complex Framework
Health New Zealand	Health New Zealand – Te Whatu Ora
ID(CC&R)	Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003
ILM	Investment Logic Mapping
JAGG	Joint Agency Governance Group
MHCAT	Mental Health (Compulsory Assessment and Treatment) Act 1992
MoH	Ministry of Health
MSD	Ministry of Social Development
NAMP	National Asset Management Programme
NASC	Needs Assessment and Service Coordination
NGO	Non-Governmental Organisation
NIDCA	National Intellectual Disability Care Agency
OPCAT	United Nations Optional Protocol to the Convention Against Torture
PBC	Programme Business Case
PV	Present Value
RFP	Request for Proposal
RIDSAS	Disability Supported Accommodation Services
RIDSS	Regional Intellectual Disability Secure Services
RMA	Resource Management Act
SRO	Senior Responsible Owner
SSM	Secure Services Matrix

A note about terminology in Disability and the High and Complex Framework

Language around disability is important. Some of the language currently used to describe the High and Complex Framework (HCF), and the related system is not consistent with the ways we should describe aspects of the HCF into the future. The language used in this document reflects current terms to avoid confusion.

The term *tāngata whaikaha* Māori acknowledges the whakaaro of Kaumātua Maaka Tibble, a Ngāti Porou disability advocate and founding member of the disability Leadership group 'Whāia Te Ao Mārama' to elevate disabled people's strength: *Tāngata whaikaha* means people who are determined to do well.

Of note in this document, is the repeated use of 'beds' as a way of describing capacity requirements. This reflects a traditionally institutional approach to the management of system capacity and does not account for the individual support arrangements that are required to support HCF clients living under the HCF. For the purposes of the Programme Business Case, it is used only as a shorthand for capacity planning.

1. Executive Summary

This Programme Business Case (PBC) proposes a multi-year investment programme aimed at addressing acute and chronic issues affecting the quality and quantity of supports received by clients being supported under the High and Complex Framework (HCF).

What is the HCF?

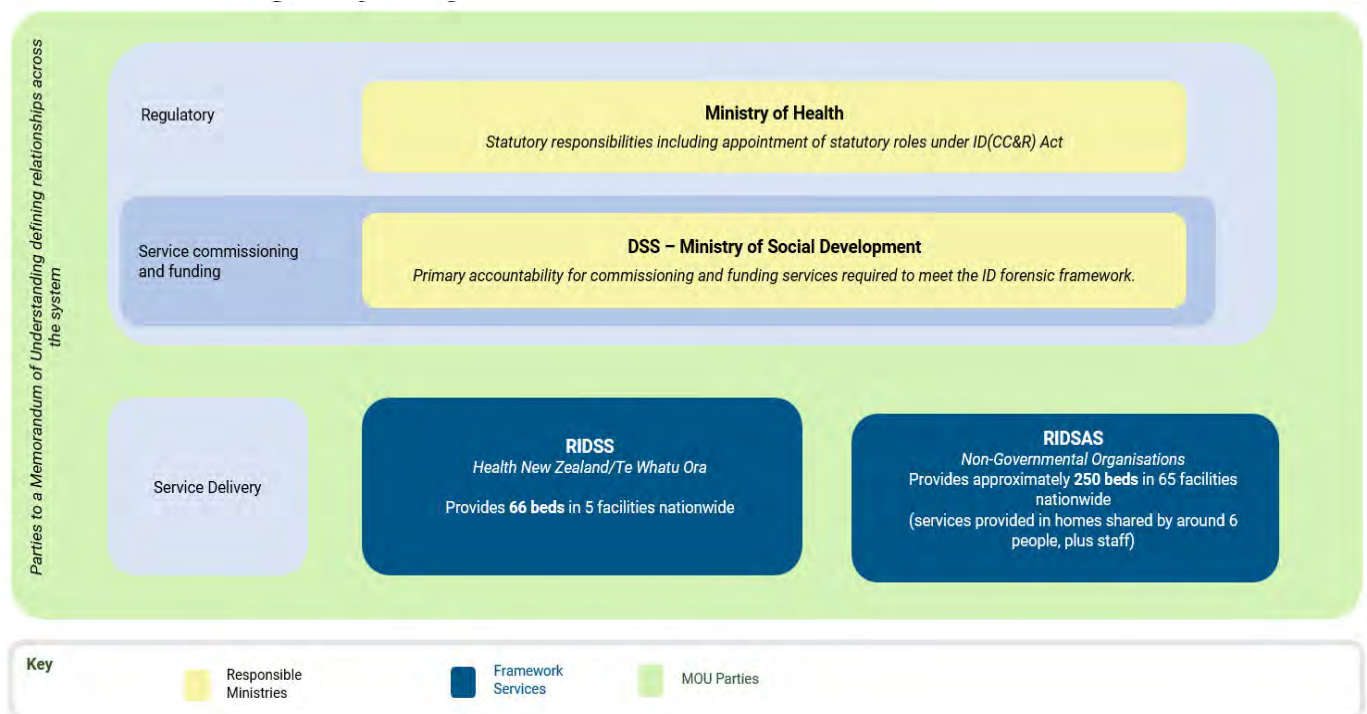
The HCF is a diversionary pathway primarily for people who have committed criminal offences, but who also have an intellectual disability and who have been found unfit to stand trial on – or have been convicted of – an imprisonable offence or who are undergoing inquiries, are transitioning off orders, or who are held under other regulatory provisions (Care Recipients). The HCF also cares for a civil population of individuals who, while continuing to receive supports within the Framework are no longer under any legal restrictions and are in a process of transferring back to mainstream services.

Since 2012, the annual average has been 294 people receiving care under the HCF, and as of July 2025, 208 people were being cared for under the HCF.

Who is responsible for the HCF?

Responsibility for the regulation, commissioning, funding, and operation of HCF services sits across several parts of the Crown, primarily the Ministry for Social Development – Disability Support Services, the Ministry of Health, and Health New Zealand. Furthermore, these agencies have been subject to major reforms in the past five years. For example, in 2022, responsibility for commissioning and funding HCF services transferred from the Ministry of Health to Waikaha (the Ministry for Disabled People), in 2024, this responsibility transferred from Whaikaha to the Ministry of Social Development's Disability Support Services Business Group (MSD-DSS). **Figure 1** illustrates current agency responsibilities for the HCF. In that capacity MSD-DSS is leading the development of this Programme Business Case.

Figure 1: Current Agency Responsibilities



What types of facilities are used to support these individuals?

There are two main types of facilities that HCF clients reside in, depending on the offence committed and the level of support an individual requires.

- **Secure Care:** Hospital level care at Regional Intellectual Disability Secure Services (RIDSS) facilities, which also includes inpatient assessment and triage for new clients in 24-hour secure environments. These services are provided by Health New Zealand in secure hospital settings. There are a total of **66 beds** currently contracted for people living under the HCF.
- **Community Secure and Supervised Care:** Residential level care based in the community at Regional Intellectual Disability Supported Accommodation Services (RIDSAS). These facilities provide community level secure or supervised care in the community. The services are commissioned from NGO providers across 65 RIDSAS facilities nationwide, with approximately 250 beds, although this number varies depending on the specific facilities available at any given time. Generally, the facilities resemble residential houses, and are owned by the NGOs or leased from the private market or from Kāinga Ora.

What are the key problems today?

The HCF faces long-standing and significant operational challenges and capacity constraints. In 2021, the Ombudsman released 'Oversight: An investigation into the Ministry of Health's stewardship of hospital-level secure services for people with an intellectual disability' (the Ombudsman's report). The Ombudsman's findings included:

- Significant capacity pressures across the HCF, resulting in court proceedings being deferred, people being remanded back to prison or inappropriately accommodated in mental health units.
- Relocation of some people to facilities outside their home regions, away from whānau and wider support networks.

The nature of the HCF population is changing, and over the past decade, the complexity and diversity of HCF clients have increased. There is an increase in younger people, women, and those with increased physical disability. The existing facilities for HCF clients are aging and were not designed with this level of complexity in mind, and this has driven the need for suboptimal operational practices (client separation, using entire wards for individual women, etc) to manage risk. This has reduced the practical capacity of facilities, and the need to manage complexity differently has meant that the practical capacity of existing facilities has decreased system flexibility.

This has resulted in serious issues noted in the Ombudsman's report. Some clients cannot be placed in appropriate facilities, and undesirable practices – like separation and use of seclusion rooms – have become necessary to manage risk. In addition, the failure of the system is leading to legal and public risk, with legal proceedings being deferred due to a lack of system capacity, and *habeas* petitions for people awaiting appropriate step-down care becoming more frequent.

These issues are captured in two key problem statements underpinning this programme of investment, which were agreed as part of an ILM for this PBC in November 2023.

1. Significant capacity pressures are stopping flow through the HCF system, resulting in missed and delayed interventions and constraining HCF access.
2. Existing HCF facilities are not fit for purpose or flexible, preventing the timely provision of safe and least restrictive, rehabilitative environments.

These problems have practical implications that risk the support and rehabilitation of those being supported under the HCF, and in the extreme, create risks to public safety. The impacts are outlined in the Strategic Case in more detail, but the key issues arising from the failure to address these problems are:

- For some years, facilities have been known to be deficient across the network. They are insufficiently flexible to accommodate the needs of people living under the HCF, resulting in more restrictive

practices than are necessary for those living under the HCF, and contributing to higher risks for staff and clients.

- Current facilities and cohort mixing practices are not providing women, children, and those with diverse needs adequate safety, privacy, or dignity in their care journeys.
- Capacity shortages adversely impact the ability of those needing support to enter and support a safe environment for those living under the HCF.
- Existing facilities do not provide adequate flexibility to respond to complex demands, which means that there are emerging and immediate issues around being able to find appropriate facilities for new people entering the system. People cannot enter the HCF without assessment, and the lack of available assessment beds and overall RIDSS capacity means that it is highly likely – and anecdotally almost certain – that there are people eligible for care, but who cannot be assessed for it or receive it.

Addressing these problems requires an immediate response to maintain the safety of those living under the HCF and to maintain public safety. The ongoing attention of the Ombudsman and inspectors to this issue also generates legal and perception risks, further adding impetus to act now to mitigate the worst issues in this system.

This means achieving the following investment objectives on which the options presented in the case are predicated:

Investment Objective 1: Sufficient flexible capacity to manage clients and meet demand. HCF providers require fit for purpose secure facilities with sufficient flexibility and capacity to respond to unpredictable demand fluctuation and increasingly complex care requirements. Fit for purpose facilities with sufficient capacity enable clients to step through the care continuum based on client suitability rather than bed availability and suitability, allowing clients to move from high security environments to community-based care. The functional layout and capacity of HCF facilities should be able to support cohort separation without limiting bed capacity for other clients or impacting relational security.

Investment Objective 2: Facilities are robust, appropriate to the cohort, and homelike. HCF providers require fit for purpose, robust and homelike facilities with physical layouts that meet the Secure Services Matrix and support cohort and client separation without reducing the functional capacity of facilities or compromising the provision of care.

Investment Objective 3: Facilities provide a safe, secure environment for staff and clients. HCF facilities require features which enable care to be provided safely and securely to clients, whilst protecting staff and minimising complicated operational practices. RIDSS facilities should have features to prevent clients from leaving without authority, such as the use of durable materials, anti-ligature fixtures and fittings, and full alarm systems. HCF clients should receive the levels of independence and freedom they are entitled to.

It's clear that the facilities are inadequate. How much more capacity is required in the system?

In addition to the inadequate nature of existing facilities, additional capacity is also required to meet the modest but real increases in demand arising from increases in (primarily) younger people and women entering the system. Bed modelling conducted by the Ministry of Health and updated by Whaikaha, suggests that at least:

- 23 additional RIDSS beds are required, and
- 10-18 additional RIDSAS beds

are required to meet the current and anticipated demand for HCF supports, provide for adequate movement of people through the system, and retain small margins for unanticipated demand.

This capacity is needed nationally, but final decisions on the allocation of these beds within each region will need to be further explored as part of subsequent business cases. Similarly, demand modelling will be reviewed and considered by the Joint Agency Governance Group (see Management Case below) to ensure that subsequent business cases rely on the latest projections.

What is the preferred response?

This business case considered 11 options, with different geographic, timing, and capacity responses. The key factors that differed across options were:

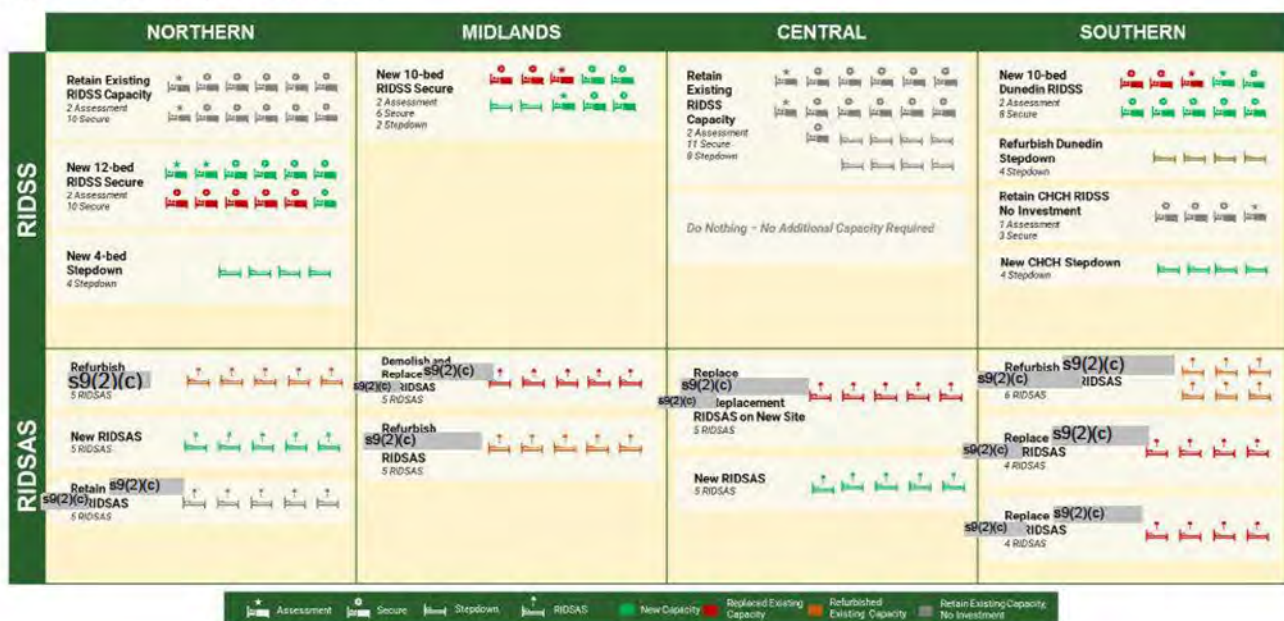
- The quantity of new capacity added;
- The level of centralisation of supports; in particular, whether to consider a strategy that centralised beds to several key regions, or maintained a greater national distribution of beds;
- Whether to start with investment in RIDSS or RIDSAS facilities;
- How and to what degree to refurbish existing facilities where possible, versus rebuild facilities that were more fit for purpose.

These options were assessed against Critical Success Factors (CSFs), and were subject to a multicriteria analysis, and a short list of options was costed. These options are articulated in the Economic Case. Ultimately, Option 4 was selected.

Option 4 focuses on providing the care continuum in each region, predominantly through the provision of new build facilities across all regions where there are existing gaps in the care continuum. A selection of new build RIDSAS facilities in Option 4 can be rebuilt on existing provider owned land (where suitable) or built on new sites, possibly acquired by the Crown.

The resulting investment, and the nature of that investment, is summarised visually in **Figure 2**, below.

Figure 2: Option 4, End State Beds



This option commences with RIDSAS builds, providing immediate capacity – and improving – of step down facilities where the greatest demand pressure is current felt. Prioritising investment in RIDSAS facilities is needed for two key reasons:

1. Increasing the capacity of step-down facilities is needed prior to increasing the system capacity for RIDSS services, so that appropriate movement through the system can be maintained.
2. The RIDSAS facilities are often most out-of-date, with none built specifically for this population. This means that in many cases the most acute upgrade requirements are present in the RIDSAS facilities.

The resulting programme of delivery and the capital costs (nominal), excluding land acquisition costs are shown in **Figure 3** below.

Figure 3: Option 4 Delivery Programme

s9(2)(j)

Option 4 provides flexible, robust, safe, and secure RIDSS and RIDSAS facilities that provide a homelike environment for HCF clients whilst protecting client, staff and public safety and balancing value for money through a mix of refurbished and new build facilities. Only those facilities that can be refurbished to meet quality and security expectations are retained for use, and additional capacity is provided as outlined in the RIDSS Bed Capacity Plan.

One of the main differences between the shortlisted Option 4 and Option 7 is the choice of service delivery model, with Option 4 focused on decentralised service delivery and Option 7 focused on centralised service delivery. While both models have advantages and disadvantages, a decentralised service delivery method for RIDSAS is preferred by MSD-DSS when considering the following:

- Centralisation of both RIDSS and RIDSAS services can support greater system flexibility as all network capacity is provided in easier to access, urban locations, making it easier for clients to transition through the care continuum without the need for extensive travel, and can enable greater workforce efficiencies.
- However, centralisation has not historically achieved desired placement outcomes and may result in a greater travel burden for clients and families who live considerable distances from centralised facilities.
- Centralised options do not technically provide the care continuum in all regions (other than centralised regions). However, Option 7, although centralised service delivery, meets the overall RIDSS capacity requirements through centralised regions.

A further benefit of Option 4 is its relatively lower capital and whole of life costs. Under the preferred hybrid programming approach, Option 7 delivers a larger number of RIDSS/RIDSAS facilities earlier than Option 4, which makes Option 7 more expensive than Option 4 on a discounted basis. For example, Option 4a (use existing RIDSAS sites) has a discounted capital cost of s9(2)(j) compared to Option 7a (use existing RIDSAS sites), which has a higher discounted capital cost of s9(2)(j). Both Option 4a and 4b have a lower whole of life cost s9(2)(j) respectively compared to Options 7a and 7b s9(2)(j). This is reflective of Option 4's lower incremental capital cost, operating cost, depreciation, and capital charge on a real basis (compared to Option 7).

MSD-DSS recognises that work is ongoing within Health New Zealand to plan for infrastructure improvements and delivery, which may result in a centralisation of RIDSS facilities beyond that considered in the preferred option in this programme business case. As part of the development of this business case MSD-DSS and CID have engaged with Health New Zealand and agreed, through the Joint Agency Governance Group, that the nature of RIDSS infrastructure will be considered as part of subsequent DBCs for RIDSS tranches.

How much money is needed? When?

There are two choices about how Option 4 is delivered. Either existing land could be used to construct new facilities, or new land might need to be acquired. This drives extremely small differences in overall capital costs.

What is being purchased? Who is responsible for what?

There are multiple agencies and NGOs responsible for RIDSS and RIDSAS delivery, and RIDSS facilities are likely to be delivered and owned by Health New Zealand. This means that this business case focuses on the following delivery and procurement considerations:

- **Focus primarily on Tranche One:** to retain flexibility and respond to changes, given the early stage of the programme and ongoing conversations with stakeholders and delivery partners. It is expected that all tranches will use a similar commercial and procurement approach.
- **Focus primarily on RIDSAS:** given that Tranche One focuses on RIDSAS, and given that further decisions are required on the best approach for RIDSS.

There are options about facility ownership and delivery responsibility: at the time of writing the PBC, neither the final ownership of the RIDSAS facilities, nor the agency that will manage the capital delivery activities, is finalised and this will be resolved through subsequent business cases. As such, RIDSAS facility ownership options are discussed, and procurement management scenarios are presented, with advantages and disadvantages.

Given the nature of existing arrangements, however, it is likely that separate contracts for each of the design, build, and hard FM services would be procured with soft FM and residential support services packaged together to integrate support and care delivery. The key components of this option are outlined below:

1. **Design Package:** One contract is let for the design of the facilities. The provider is responsible for creating designs that meet the necessary requirements and standards, ensuring that the facilities are secure, safe, accessible, and homelike.
2. **Build Package:** A second contract (which could be a separate contract or a part of a delivery consortium) is let to oversee the construction of the facilities. The contractor is responsible for executing the design plans and delivering the facilities according to the specified standards and timelines.
3. **Hard FM Package:** A third contract is used for providing hard FM services, which include the maintenance and management of the physical infrastructure. The provider(s) ensures that the facilities are kept in good condition and that any necessary repairs or upgrades are performed efficiently.
4. **Soft FM and Service Provision Package:** A fourth service provider is engaged to provide soft FM services together with resident support services. The soft FM services will encompass operational

support functions such as cleaning, landscaping, and waste management. The resident support service provision will include services to smoothly operate the facilities, keep residents safe and secure, and integrate with day-to-day living in care (e.g. assistance with cooking and laundry). It should be noted that residents are encouraged to live as independently as possible, so this package does not provide catering, laundry services or other living services as such, although staff may assist where required, as residents perform these tasks. Some parts of this package could be sub-contracted by the main service provider to other contractors (e.g. for cleaning or landscaping) or could be delivered directly by the service provider.

Facility ownership will have an impact on which agency(ies) may be best placed to take responsibility for managing the procurement process for each of the different packages.

MSD-DSS has signed a Letter of Intent (LOI) with Crown Infrastructure Delivery, and they will provide expertise and support in the procurement and/or delivery of RIDSAS facilities. The procurement strategy will be developed with CID as part of the DBCs.

Currently, RIDSAS facilities do not have consistent ownership. In some cases, RIDSAS facilities are owned by current RIDSAS service providers or rented by service providers from the private residential market. A smaller proportion are owned by Kāinga Ora and leased by RIDSAS service providers.

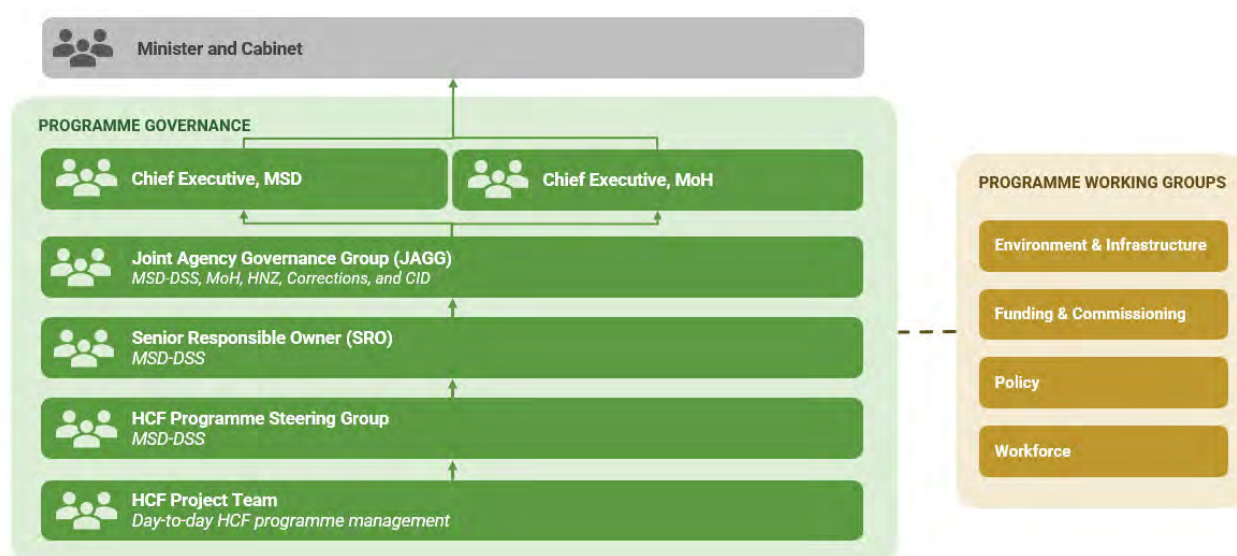
MSD-DSS considers that it makes the most sense for the government to own – or otherwise control – the physical assets for the HCF. Discussions are ongoing with Kāinga Ora and other agencies about who is best placed to own these facilities in the long term, and initial conversations with NIFF have commenced about potential alternative ownership methods. These need to be resolved and will be explored further in the detailed business case for this tranche.

What considerations have been given to programme governance and delivery? What risks remain?

The HCF programme has established governance protocols. Governance of the HCF Programme is a joint-agency responsibility, as reflected in the presence of the Joint Agency Governance Group (JAGG) with representation across MSD-DSS, the Ministry of Health, Health New Zealand (HNZ), the Department of Corrections, and Crown Infrastructure Delivery Limited. Following the Gate 0 review, MSD-DSS engaged Crown Infrastructure Delivery to lend its infrastructure expertise to the programme. A CID programme director was appointed to support the SRO, and the JAGG was reconstituted to ensure that key cross-agency accountabilities and decision-making are covered. This sought to achieve better alignment between MSD-DSS proposals for RIDSAS and HNZ infrastructure planning affecting RIDSS, and brought in the Department of Corrections to reflect ongoing legal changes impacting how individuals enter the HCF.

MSD is the Ministry ultimately accountable for outcomes and responsible for commissioning and funding HCF services; it is not the entity delivering the care services or providing the facilities. HCF facilities are contracted by MSD through Health New Zealand (RIDSS) and NGO community providers (RIDSAS).

Figure 4: Programme and Governance Structure



JAGG is primarily responsible for steering this multi-year programme of work across agencies, and managing any issues and risks in the delivery of services. This includes governance of this investment in RIDSS and RIDSAS facilities. The JAGG formalises existing cross agency work progressed through the relationships held between leaders in the agencies.

The purpose of the JAGG is to govern the HCF Programme across agencies (MSD and MoH), coordinate agencies that have roles in delivering the HCF, and act as an escalation point for issues and risks.

The JAGG formalises cross-agency governance of the HCF programme with the MoH and is responsible for driving, monitoring and reviewing progress against the strategic plan.

Programme delivery is more challenging. MSD does not have significant experience delivering capital programmes. Crown Infrastructure Delivery (CID) has been engaged to support MSD in the delivery of the RIDSAS facilities. CID has experience supporting the delivery of infrastructure projects for government agencies without core capital delivery capability and experience integrating with project teams that have limited internal capability to manage risk, finances, and reporting. Health New Zealand is best placed to lead the delivery of new RIDSS infrastructure.

While the overall direction for delivery of this investment is clear, some key risks remain. MSD is fully aware that, prior to lodging a DBC for Tranche 1, prioritisation through the renewed JAGG and gaining a clearer understanding of responsibilities across this programme's capital delivery governance, management, and ownership. Should this PBC be approved, work will continue at pace to land the key delivery relationships needed to deliver this important investment for this high-needs, high-complexity population.

2. Strategic Case

2.1 Strategic Context

This section provides an overview of the Disability Support Services group within the Ministry of Social Development (DSS-MSD) in relation to the operation of the High and Complex Framework (HCF) alongside other relevant stakeholders and makes the case for investment. Further detail on the HCF and its operation can be found in Appendix A.

2.1.1 Background to the Investment

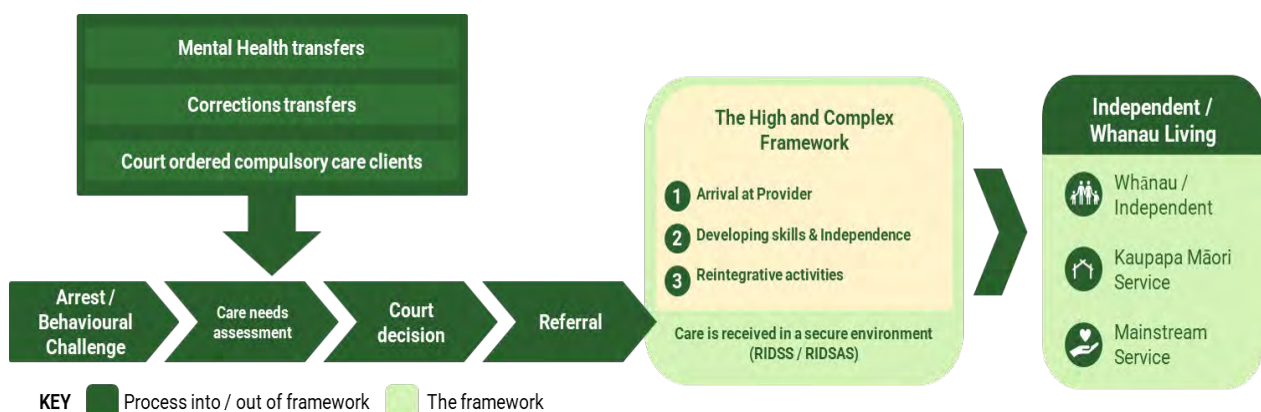
The High and Complex Framework (HCF) gives effect to the **Criminal Procedure (Mentally Impaired Persons) Act 2003 (CP (MIP))** and the **Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003**. It is a diversionary pathway for offenders with intellectual disability¹ who cannot be accommodated in standard correctional facilities. The HCF also cares for a civil population of individuals who, while continuing to receive support within the Framework, are no longer under any legal restrictions and are in a process of transferring back to mainstream services. These individuals are referred to as 'Civil Clients'. For the purposes of this Programme Business Case (PBC), the term 'HCF clients' is used to refer to Care Recipients and Civil Clients collectively.

Clients in the HCF are accommodated either in secure hospital facilities called **Regional Intellectual Disability Secure Services (RIDSS)** or in secure facilities (effectively retrofitted houses) in the community called **Regional Intellectually Disabled Secure Accommodation Services (RIDSAS)**.

RIDSS are operated by **Health New Zealand (HNZ)** within hospital sites, and RIDSAS are operated by a range of **non-governmental organisations (NGOs)** on behalf of MSD. Responsibility for commissioning HCF services passed to the DSS business group of MSD in 2024.

Care under the HCF is not intended to be permanent; clients transition from RIDSS to RIDSAS, eventually returning to the community if appropriate (see **Figure 5**).

Figure 5: Transitioning through the HCF



The HCF population is small (see **Figure 5**). Since 2012, there has been an annual average of 294 people receiving care under the HCF, as of July 2025, 208 people were being cared for under it. This decrease is related to policy changes restricting new Civil Users from entering the framework, rather than a reduction in demand from secure and supervised clients.

A snapshot of services, their scale and geographical location is set out in **Figures 6 and 7**.

¹ A detailed description of the criteria for entry can be found in the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, s.7

Figure 6: Overview of the HCF Population

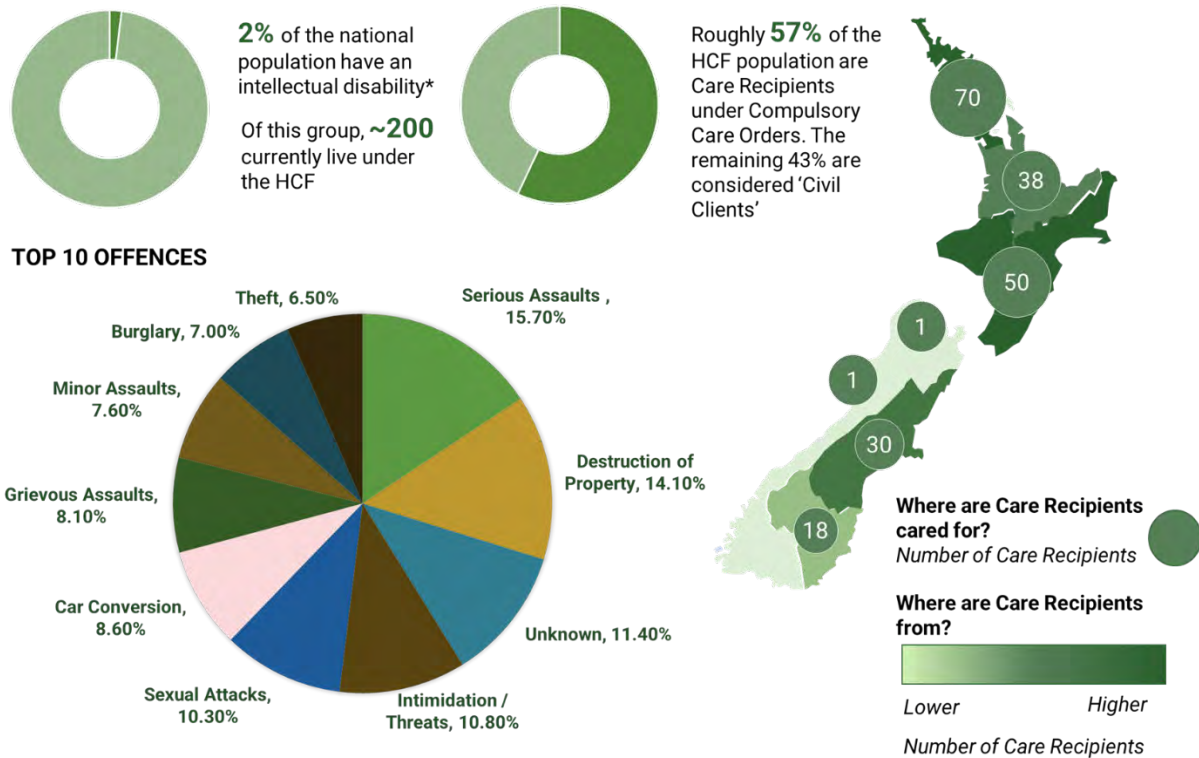


Figure 7: RIDSS facilities by region

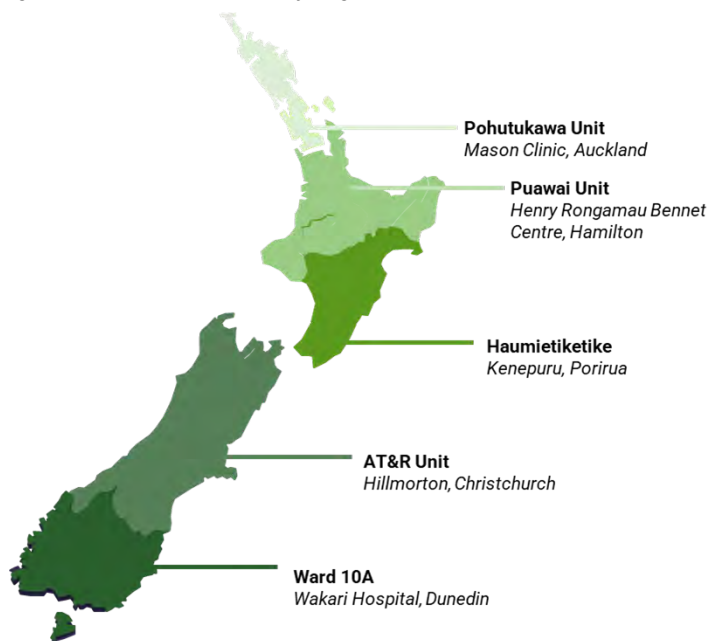
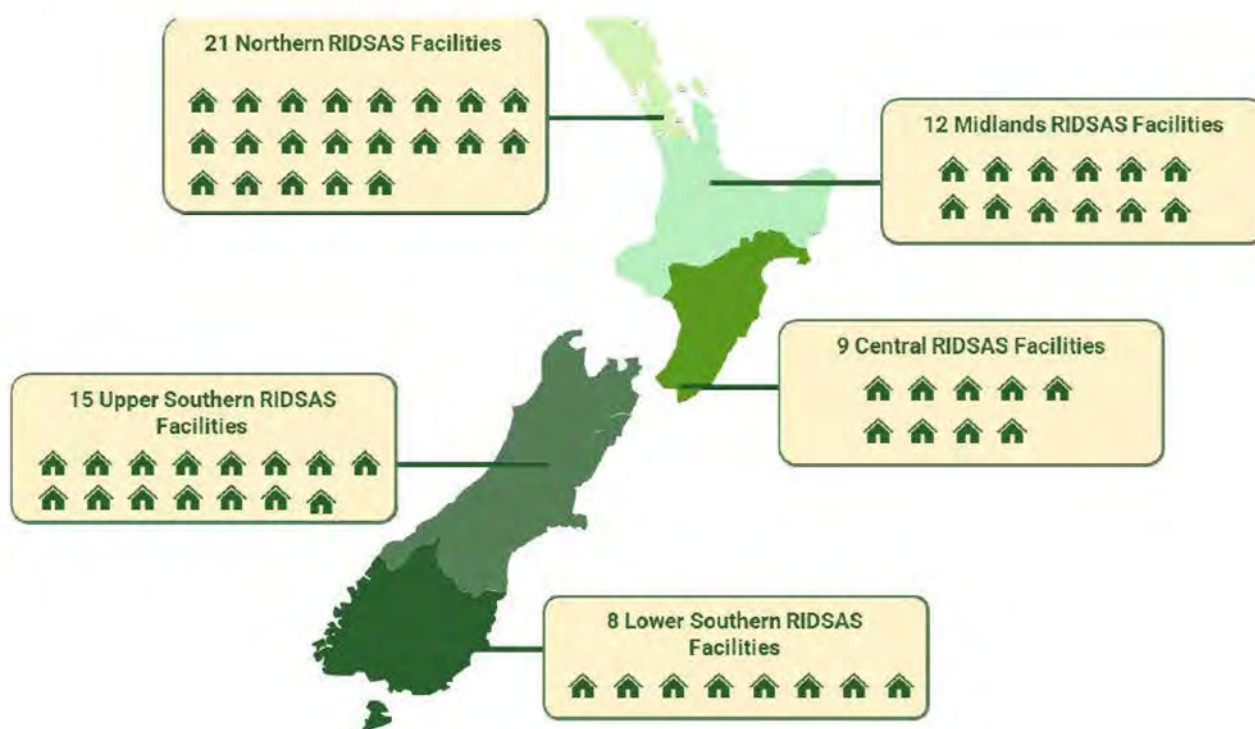


Figure 8: RIDSAS facilities by region



The Ombudsman's 2021 report: 'Oversight: An investigation into the Ministry of Health's stewardship of hospital-level secure services for people with an intellectual disability' found serious deficiencies in the operation of the HCF (then owned by the Ministry of Health – MoH). This included:

- A lack of any cohesive overarching plan to guide the effective delivery of Framework services and ensure the rights of Framework users were upheld.
- No action taken to address acute capacity issues in the HCF.
- Inadequate systems for monitoring and reviewing the overall operation of the Framework.

In 2023, Whaikaha – the Ministry of Disabled People developed an HCF Operational Strategy in response to the Ombudsman's findings. Since the transfer of disability support services from Whaikaha to DSS-MSD in September 2024, DSS-MSD has progressed work on the PBC, which seeks to give effect to the infrastructure and environment components of the Operational Strategy, as outlined in the next section and in further detail in **Appendix A**.

Separately, MSD-DSS is progressing policy work into the wider system settings, which will support the successful delivery of this investment.

2.1.2 Organisational Overview

The HCF does not have a single 'home' within the Crown. It exists across a range of agencies outlined in this section. Further details on how these interdependencies will be managed are outlined later in the Strategic Case and in the Management Case of this PBC.

- **MSD-DSS** has formal responsibility for commissioning and funding HCF services since September 2024.
- The **Ministry of Health (MoH)** has statutory and regulatory responsibility for the HCF and responsibility for administering key legislation governing the HCF. The Director-General of Health appoints several statutory roles (Care Managers, District Inspectors, Care Co-Ordinators) who have a monitoring function over HCF operations.

- Joint MSD and MoH: Under a 2025 Memorandum of Understanding, they are both responsible for responding to the Ombudsman's findings.
- **Health NZ (HNZ)** provides forensic secure hospital-level beds (RIDDS) for intellectually disabled people (contracted with MSD-DSS), while also responsible for forensic mental health unit service provision, staffing and operations.
- Other organisations have responsibility for monitoring the HCF, including the **Ombudsman** and **Children's Commissioner**, who have monitoring responsibilities under the United Nations Operational Protocol to the Convention Against Torture (OPCAT), which covers places of detention.
- **Whaikaha, the Ministry for Disabled People** is the system steward for disability issues across and beyond government, and is responsible for providing strategic policy advice, advocacy, and monitoring across all agencies on policy related to disabled people.

Further to this, there are several elements of the Crown related to the delivery of the infrastructure and services outlined in this PBC:

- **Crown Infrastructure Delivery Limited (CID)** is a schedule 4a Company focused on improving infrastructure delivery outcomes for the Crown. MSD-DSS has chosen CID as its partner to develop the PBC, subsequent DBCs, and deliver infrastructure investments outlined in each. Further details of this partnership are set out in the Commercial and Management cases of this PBC.
- **Oranga Tamariki and The Department of Corrections:** may also share clients within the HCF, i.e. some clients may move between Corrections facilities and forensic care.
- **The Courts (as administered under the Ministry of Justice):** Make sentencing decisions and referrals to the HCF for those who are found unfit to stand trial or convicted of an imprisonable offence.
- **Kāinga Ora:** Supports NGOs through the provision of houses for residential accommodation services via its Community Group Housing portfolio. These houses are either rented or leased to NGOs that are responsible for service delivery.

2.1.3 Strategic Alignment

This investment will support MSD, MoH and other agencies to meet their legislative requirements, address the deficiencies outlined in the Ombudsman's report and uphold the HCF vision and any related actions set out in the Operational Strategy and Strategic Statement.

Alignment to existing strategies, priorities, and legislation is set out in **Appendix B**.

Sector and Operational Strategy Alignment

Health Sector and Disability Sector Visions

Investment in facilities across the HCF is critical to achieving the **New Zealand Health Strategy's** vision of pae ora, which is underpinned by the goal to "achieve health equity for our diverse communities, and especially for Māori, Pacific, disabled and other groups who currently have poorer outcomes".²

Current HCF facilities are not configured to be inclusive and supportive to all demographics, are unable to provide the level of security necessary to mitigate risk of harm, and do not enable people to consistently receive the level of support needed as they transition through the framework. Investment in HCF facilities will enable MSD to better uplift and support this wider health vision by creating fit for purpose, therapeutic, and safe facilities that cater to the needs of their population demographics in the most appropriate places.

² Ministry of Health, *New Zealand Health Strategy*, accessed 8 September 2025, <https://www.health.govt.nz/strategies-initiatives/health-strategies/new-zealand-health-strategy>

The HCF PBC also aligns with the Government's **New Zealand Disability Strategy 2026-2030 (NZDS)**. The vision of the strategy is that 'New Zealand is an equitable and accessible place for all disabled people and their whānau – where disabled people thrive, contribute, and choose the lives they want to lead.' There are five priority outcome areas: education, employment, health, housing, and justice.

Improvements to the HCF relate to the justice outcome area. The NZDS goal for justice is that: 'Disabled people's human rights and freedoms will be protected, and their disability rights will be realised. Disabled people will be treated fairly and equitably by the justice system and will be supported to meaningfully participate. Justice system policies and practices will embed accessibility, inclusion and lived experience.'

HCF Operational Strategy

For years it has been recognised that a step-change in investment is needed for agencies to meet HCF delivery obligations and uphold the HCF vision.

Following the release of the **2021 Ombudsman Oversight Report**, the **Operational Strategy** was developed. Commissioned by Whaikaha³, the Operational Strategy incorporates the voices of HCF clients, Māori, providers, and forensic disability sector subject matter experts to articulate a vision for the future of the HCF:

"All Care Recipients and their whānau are supported to live safe, fulfilling lives where they can make meaningful decisions as leaders of their care journey, and their voices are elevated in decisions regarding the High and Complex Framework system and its services."⁴

This Operational Strategy explored critical challenges and identified solutions to improve HCF operations across four domain areas: Environments and Infrastructure, Workforce, Policy and Operations, and Funding and Commissioning. A key action was to develop a Programme Business Case seeking capital investment to upgrade outdated and constrained HCF infrastructure.

Capacity constraints are preventing the HCF from maintaining a safe, accessible system for people who require this type of intensive care and management. The functionality and sustainability of the framework is compromised, and breaches are occurring. These are set out in **Section 2.2.1**.

This PBC proposes essential investment in critical environmental and infrastructure issues to address critical capacity pressures induced by run down, not fit-for-purpose, inflexible RIDSS and RIDSAS facilities. The proposed investment will support the HCF Environments and Infrastructure Vision (as expressed in the Operational Strategy) whereby:

HCF clients and staff will live and work in environments that feel familiar and safe, and that uplift their cultural, spiritual, and physical wellbeing.

This also means that:

- The environment supports stable, collegial relationships, where staff support HCF clients and tāngata whaikaha Māori to work together to meet shared goals.
- The physical space is flexible in design with multi-purpose, multi-functional spaces; it is homely, bright, and warm. It is easily maintained and has flexible spaces for different needs, including whānau visits. It reminds people living within the framework, tāngata whaikaha Māori and staff that this is their home, and it is focussed on their wellbeing.

³ Note that when the Operational Strategy was developed, Whaikaha was responsible for commissioning disability support services and this role has now transferred to MSD.

⁴ Whaikaha – Ministry of Disabled People, High and Complex Framework Operational Strategy, accessed November 2025

Wider Strategic Alignment

This investment will support the Government's response to the Royal Commission of Inquiry into Abuse in Care

In June 2024, the Royal Commission of Inquiry into Abuse in Care reported that '[a]buse and neglect were pervasive in social welfare, Deaf, disability, and mental health residences and institutions.'⁵ This included the forerunners to the present-day HCF. The findings of the Commission carry significant and challenging implications for housing vulnerable people with intellectual disabilities under compulsory care and rehabilitation. It highlights historical systemic failures and the need for comprehensive reform across the system. Investment is needed to enable them to lead safe, fulfilling lives throughout their rehabilitation pathway.

The Inquiry found that disabled people, including those with intellectual disabilities, were more likely to be placed in State and faith-based care for longer periods and were disproportionately subject to abuse and neglect compared to non-disabled people. It found that legislative and policy settings did not ensure sufficient emphasis on alternatives to placing Deaf and disabled people and people experiencing mental distress into institutionalised care, like exploring family or community-based care options.

In response to the inquiry, the Government amended the Crimes Act 1961 to specifically include disability within the definition of a vulnerable adult. Ill-treatment or neglect of a vulnerable adult (s.195) and failure to protect a vulnerable adult (s.195A) are criminal offences.⁶

The Inquiry made 138 recommendations, many of which are relevant to the HCF. **Table 3** outlines some specific examples and explains their relationship to the HCF programme and proposed investment.

Table 3: How the proposed investment relates to the Royal Commission of Inquiry on Abuse in Care's recommendations

Recommendation number	Recommendation	How the proposed investment addresses the recommendation
57-64	Staff and care workers to be vetted, registered, and well trained.	The non-build workforce components of the wider HCF programme seek to address these recommendations.
71	The government should, as a priority, support and invest in the development of disability and mental health, educational and youth justice models of care that do not perpetuate the institutional environments and practices including segregation that led to historic abuse and neglect in care.	The proposed investment seeks to provide facilities which prioritise client wellbeing and minimise harmful practices.

⁵ <https://www.abuseincare.org.nz/reports/whanaketia/part-4/chapter-6>

⁶ [Crimes Act 1961 No 43 \(as at 30 October 2025\), Public Act 195A Failure to protect child or vulnerable adult – New Zealand Legislation](#)

74	The government should prioritise and accelerate work to minimise and eliminate solitary confinement in all care settings as soon as practicable, with an emphasis on person-centred and culturally appropriate approaches to reduce the use of solitary confinement safely.	
75	All State and faith-based entities providing direct or indirect care to children, young people and adults should review physical building and design features to identify and address elements that may place children, young people and adults in care at risk of abuse and neglect.	
79	The government and all relevant decision-makers should review existing policy, standards, and practice to ensure that all involuntary care placements are suitable and support connection to whānau and community. This includes placements being located as close as reasonably practicable to the family or whānau of the children, young person or adult in care.	The preferred way forward for this PBC seeks to ensure that clients are cared for in locations accessible to family and whānau.

This investment will support agencies to deliver on wider strategic priorities and to adhere to legislative responsibilities.

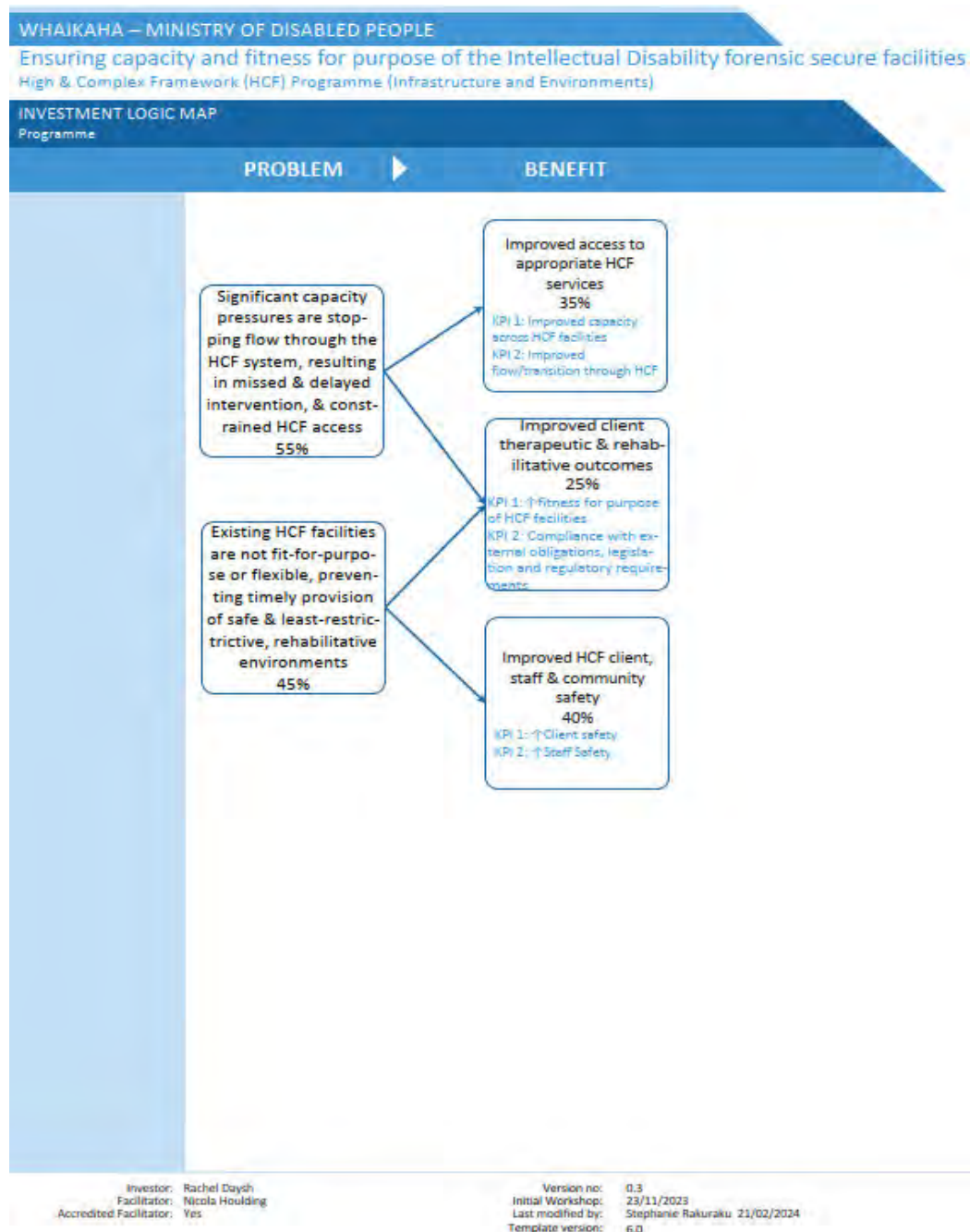
There are also other existing strategies and legislation informing, and informed by, the outcomes and benefits of investment in the HCF. Appendix BB provides a comprehensive view of this strategic environment and its relevance to this proposed investment.

2.2 The Need for Investment

Investment Logic Mapping (ILM) workshops were conducted by an accredited facilitator in November 2023 and January 2024 with key stakeholders representing Whaikaha⁷, Health New Zealand, Kāinga Ora, and the operational arms of the RIDSS and RIDSAS providers. These workshops crystallised the purpose of this investment and clearly articulated the problems and benefits that an infrastructure response for HCF facilities is designed to address. Two infrastructure driven problem statements were agreed upon, along with 3 key benefit areas as shown in the Investment Logic Map diagram below.

The PBC focuses on addressing infrastructure-driven deficiencies in the system. Following feedback at the Gate 0 review, the Model of Care has been reviewed alongside the development of this PBC, and any updates will be incorporated in future DBCs (see Management Case for more detail on responses to Gate 0 recommendations). MSD-DSS is undertaking separate workstreams to address contracting, workforce attraction, and cultural challenges. DBCs for tranches of facilities – which will result should the PBC be approved – will focus on site specific requirements, model of care implementation, and workforce challenges specific to each site or region.

⁷ Note that the ILM was conducted when Whaikaha commissioned all disability support services. This responsibility has now shifted to MSD and the problem statements and benefits remain unchanged.

Figure 9: Investment Logic Map⁸

⁸ Note that the ILM was conducted when Whaikaha commissioned all disability support services. This responsibility has now shifted to MSD and the problem statements and benefits remain unchanged.

2.2.1 Problem Statements

Existing HCF facilities do not enable HCF clients to live safe, fulfilling lives, where they are supported to make meaningful decisions as leaders of their care journey. Significant and systemic infrastructure issues limit access to care and compromise safety and wellbeing.

Table 4 provides an overview of the key issues in some RIDSAS and RIDSS facilities. Many of these issues sit across the two problem statements (i.e. capacity constraints contribute to making RIDSS and RIDSAS facilities not fit for purpose). Appendix A outlines further detail on the problems.

Table 4: Summary of key issues in a selection of RIDSAS and RIDSS facilities

Topic	Key Issues Identified
RIDSS Facilities	
Managing Complex Cohorts	- Inability to separate users who should not be in close proximity within ward environments such as HCF clients and offenders/non-offenders. - The physical layout of the facility results in use of a sub-optimal solution to meet the unique needs of an individual. For example, using a space for a purpose it was not designed or intended for, or significantly modifying an environment to the point that it 'blocks' the use of the space for other users (e.g., for admission or assessment). - A lack of step-down options or transition pathways, resulting in long-term placement of HCF clients due to lack of other appropriate accommodation.
Gender Separation	- The physical layout of some facilities does not enable gender separation meaning female clients are often accommodated with male clients. - Efforts to support gender separation result in the use of sub-optimal spaces that do not support least restrictive care practices. Often this means female clients receive varying models and quality of care depending on the physical layout of a given facility. - Some female spaces do not have ensuite bathrooms, limiting the independence of female clients.
Communal Spaces	- Facilities often appear tired, musty, crowded or lack natural light. - Some facilities lack appropriate communal spaces and some have no separate communal areas specifically available for female HCF clients.
Supporting Least Restrictive Environments	- To manage the complexities of mixed HCF client cohorts, restrictive practices are often applied to all HCF clients irrespective of a person's legal status or risk. This subjects all HCF clients to the same level of restriction irrespective of their risk. - The physical layout of facilities limits staff ability to provide least restrictive care. For example, limited access to private spaces, internet or phone services, and/or fresh air. - A lack of appropriate private spaces in facilities means that de-escalation or seclusion rooms are often used inappropriately to provide users with a private space or to transition users from seclusion back into the main ward. - A lack of appropriate spaces can result in 'bed blocking' and a lack of available or adequately resourced supported accommodation, preventing users who could potentially reside in community living from making the transition. - To manage the risk of mixed gender accommodation, staff sometimes have to apply 1:1 management to female HCF clients due to staff shortages to maintain their safety (rather than 1:1 management for male clients). This practice unfairly limits the freedoms and independence of female HCF clients.
RIDSAS Facilities	

Topic	Key Issues Identified
Managing Diverse Cohorts	- The ownership or operational arrangements for some facilities mean that the property is unable to be renovated, meaning facilities continue to lack the physical layout and flexibility required to accommodate the needs of secure clients. - The continued use of facilities with an inflexible physical layout results in 'bed blocking' and sub-optimal care practices that prevent flow through the HCF system and/or cause disruption for existing and incoming clients. - Management of clients with especially complex needs can result in blocking off an entire space that was originally designed to accommodate multiple clients for a single user, reducing the effective capacity of a facility. - Resource consenting issues with the local consenting authority prevented the use of the property as a secure facility.
Communal Spaces	- In some facilities, significant upgrades are required to meet the expectations for a secure facility. These upgrades may include replacement of all windows and frames to manage escape attempts, window coverings to support sensory needs, or installation of re-programmable locks for added security. - The need for significant upgrades to meet the expectations for a secure facility is sometimes the result of converting a property once used for an unrelated function into a secure facility. - Some facilities lack multi-functional spaces, or have appropriate spaces in poor condition, preventing communal use. These spaces need to be robust enough to provide suitable secure care.
Supporting Least Restrictive Environments	- In conjunction with having physical facilities that meet the requirements for providing secure care, a facility must also be able to provide 24/7 staffing. - Ownership structures often prevent secure facilities from implementing changes to support least restrictive environments. - Facilities vary in their ability to provide the environmental security necessary for secure facilities. For example, large rural properties are unable to be fully fenced. - Limited RIDSS capacity can result in clients being inappropriately cared for in RIDSAS facilities, preventing flow through the HCF system. - Residential consenting issues limit care options for providers. - Residential care facilities have to consider their proximity to busy roads and neighbourhoods to limit the impact of user behaviour on the surrounding area.
Other Observations	- Refurbishment does not always make a property fit-for-purpose and ongoing maintenance is required to address damage caused by clients. - There is a balance required between a secure facility meeting 'functional' requirements to enhance security for staff and users and creating a welcoming space such as through access to the outdoors. - Lack of affordable housing in area can limit a provider's ability to acquire larger or more suitable housing.

Problem Statement 1: Significant capacity pressures are preventing flow through the HCF system, resulting in missed & delayed intervention & constrained HCF access.

Executing the Model of Care for the HCF demands a system with sufficient capacity and flexibility to respond to changing demands and allow for movement through the system as acuity changes.

The capacity constraints in the system, and the lack of flexibility in the use of beds for different needs has led to prevalent bed-blocking, essentially blocking off entire areas to accommodate a single individual with complex behaviours, or to manage the safety of a mixed-gender environment. This has the consequential impact of reducing practical capacity. The impact is threefold: people are unable to enter the system, they often encounter more restrictive environments once they are there, and safety is compromised.

Bed capacity continues to remain critical for a range of bed types, including care and rehabilitation beds and assessment beds. At times, the only capacity available may be within a Forensic Mental Health Secure Unit, which can compromise care due to the differing needs of Forensic Mental Health and Intellectually Disabled clients. Several regions have reported that they are no longer able to accept secure HCF clients and are declining new court referrals. Furthermore, increased pressure in some regions has led to HCF clients moving to another region for care, causing flow on impacts to capacity pressures.

RIDSAS providers have similar challenges, with a lack of capacity preventing transition to more appropriate care and creating a functional 'backlog' at RIDSS facilities. As of December 2023, three regions (Auckland, Midland and Canterbury) are at capacity and cannot take further referrals.

This need has been heightened by changing demographics that means facilities need to be used differently, reducing practical capacity.

Over the past decade, the complexity and diversity of HCF clients have increased. There is an increase in younger people, women, and those with increased physical disability. They are younger, meaning they stay longer in care, and require different facilities to meet their needs. Often, they present with comorbid mental and physical health conditions that require a higher level of medical and psychiatric care than was planned for when the HCF was developed. The complexity of the cohort has meant that facilities do not have enough functional capacity, particularly in regions from which many people eligible for the HCF originate, making it difficult to locate clients near their whānau.

The HCF also now accommodates greater cohorts of HCF clients that were not anticipated when the HCF was established 20 years ago. This includes HCF clients with very high needs, women (who now represent up to 16 per cent of HCF clients), and younger HCF clients. Managing this diverse cohort can require the use of 'bed blocking' to ensure a safe distance and lack of contact with others is maintained, and there are cases where the design of facilities means that up to 4-beds at one time are needed to manage high-complexity clients or maintain gender separation.

As such, not all beds can be made available to support HCF clients, and actual capacity is lower than the number of physical beds. With such small numbers - most RIDSS facilities have less than 15 contracted beds – this can lead to significant swings in functional capacity, which means facilities require greater flexibility to manage these complex and often changing needs.

Table 5: FY23 RIDSS Capacity and Occupancy⁹

Region	Capacity	Occupancy (Dec 2023)	% Occupancy (Raw)	Next 5 Years Forecast Total (Increase)
Northern				
Assessment & Secure	12	10	59%	24(+7)
Stepdown/Cottage	-			4 (+4)
Midlands				
Assessment & Secure	3	3	100%	8 (+5)
Central				

⁹ While capacity pressures are increasing, the total demand in the system is relatively constant. This table represents the most recent information available. Capacity predictions will be confirmed in subsequent business cases.

Assessment & Secure	13	11	85%	13 (+0)
Stepdown/Cottage	8			8 (+0)
Canterbury (Upper South)				
Assessment & Secure	4	4	100%	4 (+0)
Southern (Lower South)				
Assessment & Secure	3	3	100%	10 (+7)
Stepdown/Cottage	4			4 (+0)

Problem Statement 2: Existing HCF facilities are not fit-for-purpose or flexible, compromising provision of safe & least restrictive, rehabilitative environments.

The HCF requires well designed facilities that support the overlapping clinical, operational, and secure aspects that RIDSS and RIDSAS must deliver.

Many facilities were designed for a different era of care, are not fit for purpose, are in poor condition, and have physical limitations that cannot meet HCF Care Recipients and Civil Clients' needs and which adversely affect safety. The layout of many facilities impedes the ability to provide all HCF clients with the level of safety, privacy, and dignity they are entitled to.

One of the critical failings of the existing facilities are their lack of flexibility to accommodate differing needs. This results in more restrictive practices than necessary and contributes to higher risks for staff and clients.

The inability of the physical environment to support the complex client mix contributes to ongoing elevated risk at RIDSS facilities. "Workarounds" used to accommodate clients in inappropriate areas (e.g., seclusion or de-escalation areas) further impede staff's ability to safely mitigate high risk situations. In turn, this leads to increased incidences of assaults and can make it challenging for services to retain staff.

s9(2)(a) , has been in a hospital-level secure service for more than five years. She has also spent time living apart from others. Between 2017 and early- to mid-2019, s9(2)(a) lived alone in a four-bedroom area. This had an impact on the placement of other, male, service users. In late 2019, another female service user moved into s9(2)(a) area, and they have continued to share this space.

Separation from other cohorts is also a feature of tailored therapeutic care. For example, the busy, noisy, and crowded environment presented by a secure level hospital ward can induce stress, anxiety, and challenging behaviours in HCF clients with autism due to overstimulation. Tables in **Appendix A** set out more detailed issues with facilities.

s9(2)(a) , has spent more than 18 years living in a forensic mental health unit.

s9(2)(a) intensive support needs are incompatible with his lengthy placement in the unit.

s9(2)(a) has sensory sensitivities and is particularly reactive to sound....

After several behavioural incidents, s9(2)(a) was moved from the main part of the unit into a seclusion room.... At times, s9(2)(a) was spending 'up to 22 hours of the 24-hour day ... with little or no interaction with others'.

The current facilities are failing clients, staff, and the wider community.

People living within the HCF have primarily committed assaults, sexual offending, or destruction of property offences (see **Appendix A**). The violent nature of these offences has impacts for the safety and security of staff, and the need for flexible facilities that support this. In addition, facilities must be both hardwearing to handle high maintenance conditions, whilst ensuring soft furnishings and a 'home-like' environment.

The security guidelines for HCF facilities are detailed in the 'Secure Services Matrix' (SSM) (**Appendix B**). Further work to develop a standard infrastructure grading system and monitor RIDSAS facility compliance with this is being planned for as part of the HCF Operational Strategy implementation programme and will be developed as part of the Detailed Business Case process (see **Section 6.11.2** below).

Currently, RIDSAS are typically retrofitted houses that have not been designed to meet secure requirements. Consequently, these facilities cannot always safely and effectively accommodate HCF clients with higher needs. There is a correlation between high incidents of abscondments and the quality of facilities, and the prevalence of assaults (clients on staff, staff on clients, and clients with each other) due to confined living spaces, limited safety and security mechanisms or segregation spaces that can be utilised quickly. Facilities are also often unable to safely accommodate meetings and visits that are a feature of regular operational activity, for example, whānau visits or external medical or legal visitors, where there is limited privacy for these meetings. With a dysregulated population, these disruptions to routine can often result in altercations, and visitors having to interact with the whole household group.

An arson incident at a RIDSAS facility in Auckland resulted from a HCF client barricading themselves in the kitchen and lighting a fire to draw attention to themselves, whilst staff were dealing with another upset client at the other end of the house.

The fire blocked the long hallway, preventing staff access, however because the facility is clustered with other RIDSAS properties in a cul-de-sac, staff were co-located and able to access and diffuse the situation through an external door.

Location features such as a cul-de-sac, a semi-rural neighbourhood or surrounding landscaping (i.e. hills or fields) can play a significant role in the function of safe and secure RIDSAS facilities.

Many RIDSAS facilities also have high maintenance requirements as they suffer repeated damage during situations where HCF clients exhibit challenging behaviour, and fixtures and fittings are not designed to the standard required to have resiliency. As a result, walls, doors, and windows often require frequent maintenance to repair damage and maintain quality, fit-for-purpose residences. Funding mechanisms for providers to make these repairs quickly and easily are limited, and so facilities can often be in various states of disrepair, and/or be managing workarounds that are not fit for purpose. In 2025, \$10m of budget funding was received to address short-term critical needs in HCF infrastructure in the years 2025-26, 2026-27, whilst longer term investment planning (this PBC) was undertaken. However, this funding covers only the most essential repairs and maintenance, not bringing facilities up to a standard of compliance with the security matrix (which is the focus of this PBC).

298 instances of property damage have occurred in RIDSAS facilities across the country since 2019, with 75 instances of property damage occurring in RIDSS facilities over the same time. There were also 332 reported instances of abuse and assault and 156 instances of unauthorised leave of a disabled person under a court order in RIDSAS facilities between 2022 and 2025, highlighting the need for robust facilities to support the safety of clients, staff, and the community.

Poor quality, 'band aid' repairs and refurbishments are expensive and limit the suitability of the property. Overall, the HCF is unable to provide appropriate, least restrictive, and timely care due to significant and systemic facility and infrastructure challenges. Investment is needed to enable HCF clients to lead safe, fulfilling lives as leaders of their care journey. Access to care is a critical challenge, and while all people who require care within the HCF will generally receive placement in a RIDSS or RIDSAS facility, they may not experience the right support and care to meet their needs appropriately and safely. HCF clients may reside in an environment more restrictive than required, or one that does not have the security and robustness needed to manage their care.

Facilities have not been designed to meet the needs of the populations that receive care under the HCF. Investment in each region is needed to provide robust, fit for purpose facilities that support provision of care

across the HCF care continuum¹⁰, flexibly respond to increasingly diverse HCF clients, provide a safe work environment for staff, and improve flow through the HCF. The benefits of investing in improving HCF facilities are further articulated in **Section 2.4.1**.

2.3 Investment Objectives, Existing Arrangements & Business Needs

An ILM was held on 7 March 2024 with representatives from Whaikaha, RIDSS and RIDSAS service providers and determined and agreed on the four Investment Objectives described in **Table 6**.

Table 6: Summary of existing HCF arrangements and business needs

Investment Objective 1		Sufficient flexible capacity to manage clients and meet demand
Existing Arrangements		Many existing HCF RIDSS and RIDSAS secure facilities are not fit for purpose and do not enable staff to provide flexible and least restrictive care. A lack of functional capacity and closing off of beds means individuals eligible for HCF care cannot access services and those already in the HCF system are blocked from stepping through the care continuum to support the provision of least restrictive care as their needs change over time.
Business Need		HCF providers require fit for purpose secure facilities with sufficient flexibility and capacity to respond to unpredictable demand fluctuation and increasingly complex care requirements. The functional layout and capacity of HCF facilities should be able to support cohort separation without limiting bed capacity for other clients or impacting relational security.
Investment Objective 2		Facilities are robust, appropriate to the cohort, and homelike
Existing Arrangements		Existing facilities have not been designed to meet the Secure Services Matrix. The layout of many existing HCF facilities does not support the separation of cohorts or individuals, limiting the ability of care providers to provide quality care outcomes. Some existing facilities are not hardwearing enough to withstand adverse client behaviours or furnished to provide an adequately home-like or therapeutic environment.
Business Need		HCF providers require fit for purpose, robust and homelike facilities with physical layouts that meet the SSM and support cohort and client separation without reducing the functional capacity of facilities or compromising the provision of care.
Investment Objective 3		Facilities provide a safe, secure environment for staff and clients
Existing Arrangements		The functional layout and condition of existing facilities do not sufficiently mitigate safety risks to clients and staff. Many existing facilities do not meet the requirements of the SSM, which can lead to adverse events such as abscondments or property damage. Facility layout often requires greater staff to client ratios to safely manage operations. Limited available secure capacity across New Zealand has increased the number of clients able to be accommodated at a given time, and is more difficult for staff to manage in a way that promotes the least restrictive care and safety.
Business Need		HCF facilities require features which enable care to be provided safely and securely to clients, whilst protecting staff and minimising complicated operational practices. HCF clients should receive the levels of independence and freedom they are entitled to.
Investment Objective 4		Facilities protect public safety
Existing Arrangements		Existing HCF facilities do not typically meet all procedural, relational, or environmental security requirements (specified in the SSM) and cannot safely and effectively prevent

¹⁰ The term care continuum is used throughout the PBC to refer to a client's journey from the high security RIDSS to RIDSAS community placements where they can live a safe and less restricted life.

	and manage client behaviours such as abscondments, assault, property damage or restraint. These behaviours can have a negative impact on surrounding communities and result in unsafe public interaction.
Business Need	HCF facilities must be of an appropriate level of quality and have the appropriate security elements required to minimise abscondments and unplanned or unsafe interactions with the public.

2.4 Main Benefits, Risks and Constraints

2.4.1 Benefits

Capital investment in HCF facilities across New Zealand will improve access to appropriate services across the care continuum, which means clients are placed in the level of care that suits their care needs rather than based on capacity. Adequate capacity across the care continuum allows for more timely transition into and through the system and reduces the need to use restrictive care practices. This allows clients to transition from high security environments to community care with greater flexibility.

A key benefit of investment in HCF facilities is improved client therapeutic and rehabilitative outcomes. When facilities better support the needs of clients through the provision of safe, secure, therapeutic, appropriate, and homelike care, workplace morale is boosted, and staff are more likely to be engaged and attracted to work in HCF facilities.

A further benefit of investment in HCF facilities is improved safety for clients, staff, and surrounding communities. Purpose-built and fit-for-purpose facilities that comply with security guidance for HCF services reduce the number of adverse events such as abscondments and destructive behaviour. This supports clients to feel safe in their environments, free from assaults and self-harm. When the facility layout and fixtures support security, staff feel safer both physically and psychologically and can provide a better quality of care. When the number of safety incidents is reduced, workforce wellbeing and morale are boosted. Furthermore, more robust and secure facilities can reduce safety incidents that result from community interaction. This increases public safety by reducing the prevalence of abscondment related incidents and subsequently improves the perception and acceptance of HCF facilities in the community.

Table 7 outlines the high-level benefits associated with HCF facility investment.

Table 7: High-level HCF Investment Benefits

Benefit	HCF clients	Whānau	Staff	MSD	RIDSS / RIDSAS Care Providers	New Zealand Public
Improved access to appropriate HCF services and flow through the care continuum	Direct	Direct		Indirect		
Improved client therapeutic and rehabilitative outcomes	Direct	Indirect				
Improved safety for clients, staff, and community	Direct		Direct			Direct
Improved capacity flexibility	Direct		Direct			
Reduction in operational costs (e.g. maintenance)				Direct	Direct	
Reduction in the prevalence of adverse events	Direct		Indirect	Indirect	Indirect	

Benefit	HCF clients	Whānau	Staff	MSD	RIDSS / RIDSAS Care Providers	New Zealand Public
Improved staff wellbeing and morale			Direct			
Improved compliance with HCF regulatory requirements				Direct	Direct	
Improved cohort separation	Direct		Indirect			
Improved Whānau connection	Direct	Direct				

2.4.2 Risks

Risk is the effect of uncertainty on achieving objectives and includes the consideration of both threats and opportunities. The most significant strategic risks that might prevent, degrade, or delay the achievement of the Investment Objectives are identified in **Table 8**. A gross risk rating on a scale of Low, Medium, High and Very High has been assigned by considering a combination of the likelihood and consequence of the risk. These risks can also be found in the HCF Programme risk register in **Appendix B**.

Table 8: Investment Risks

Risk		Risk Rating Pre-mitigation	Risk Management and Mitigation Strategies
1	IF key stakeholders have not been informed throughout the PBC development process and roles are not well defined between agencies THEN it may result in misaligned expectations WHICH may result in delays to the programme.	Very High	Meet with delivery agencies and other key stakeholders to define roles and responsibilities and circulate agreed actions and decisions. Engage with key stakeholders and delivery agencies early to support decision-making. Continue to update the Programme Stakeholder Engagement and Communications Strategy.
2	IF the direction of the programme changes due to changes in authorising environment THEN the programme may require significant changes WHICH may adversely impact the ability to meet statutory obligations and provide safe care for people under the HCF.	Very High	Continue to update the Programme Stakeholder Engagement and Communications Strategy to communicate recommended investment to decision-makers.
3	IF the Crown cannot purchase existing RIDSAS facilities/land from providers THEN changes to the Preferred Option may be required to reduce the investment risk to the Crown WHICH may result in delays to the programme.	Very High	Continue to update the Programme Stakeholder Engagement and Communications Strategy with clear messages and communication channels to engage with providers. Development of a realistic preferred option with a series of new builds on new land and new builds/refurbishment on existing land, which could be adapted to align with the ownership decisions made. Tranche One investment only includes one refurbishment with three new builds, with no existing ownership discussions required.

Risk	Risk Rating Pre-mitigation	Risk Management and Mitigation Strategies
4 IF programme governance and wider government are not kept informed THEN endorsement and approvals process may be delayed WHICH may result in a lack of timely investment in HCF facilities and an adverse impact on quality of care.	High	Development of detailed programme timeline with timelines for approvals by approving party, circulated to approvers in advance. Engage with stakeholders early. Regular engagement with programme governance (JAGG). Continue to update the Programme Stakeholder Engagement and Communications Strategy.
5 IF significant government partners do not endorse the RIDSS investment timeline THEN the capacity and condition in RIDSS facilities could worsen and reduce movement through the care continuum WHICH means recipients will not get access to the care they require.	High	JAGG established in April 2025 to oversee the HCF joint agency work programme (which includes this HCF RIDSS and RIDSAS facility investment). Crown Infrastructure Delivery Programme Director appointed November 2025 to review and refresh JAGG terms of reference and membership, particularly with a view to including senior HNZ representation to ensure alignment between RIDSAS and RIDSS planning. New membership and terms of reference confirmed January 2026 and new JAGG now meeting monthly.
6 IF the programme does not receive funding from Cabinet THEN RIDSS and RIDSAS capacity and quality issues will persist WHICH could contribute to regulatory breaches.	High	Early engagement with Treasury and communication with Ministers to discuss importance of the programme. Regular engagement with programme governance to make the programme a continuous MSD and sector priority and emphasise the consequences of not investing in the programme for clients, whānau, and staff. Contingency planning is being undertaken should the investment not proceed. The B25 investment of \$10m over FYs 2025-27 can be used to address minor maintenance and repair issues, but will not address any of the broader problems identified in this PBC, or bring facilities that are below compliance up to compliant standard.

2.4.3 Constraints, Dependencies, Assumptions, and Considerations

This PBC seeks funding to develop fit-for-purpose RIDSS and RIDSAS facilities to accommodate HCF clients in environments appropriate to their needs. These investments will also provide needed flexibility throughout the system to support the long-term care journey.

Wider System Context

While this investment will address some HCF system wide issues, this is an investment in physical infrastructure and will predominantly provide benefits associated with the built environment in which clients receive care. The extent to which this investment can fully address system challenges and achieve wider benefits is contingent on the delivery of other actions outlined in the HCF Operational Strategy. While investment in physical infrastructure delivers benefits, other changes are required to maximise the benefit

received from the investment. Relevant actions across the environments and infrastructure, workforce, policy, operations, and funding and commissioning domains outlined in Table 9 will support the investment in physical infrastructure and/or achievement of the Investment Objectives. For each strategic response outlined in **Table 9**, there are numerous detailed actions MSD are considering through implementation planning.

Table 9: Selected Relevant Strategic Responses from the HCF Operational Strategy Detailed Action Plan

Strategic Responses	
Environments and Infrastructure	
E.1.2	Identify and assess options for increased housing supply
E.2.1	Develop minimum design standards based on Enabling Good Lives principles, Autism Guidelines, therapeutic care methodologies and flexible use of spaces that enable safety for staff and people in care. Work with specialists to determine how standards can best meet RMA/resource consent requirements
E.2.2	Commission a nationally consistent High and Complex service continuum
E.3.1	Develop maintenance and conditions standards for existing facilities to prioritise investment
E.3.3	Assess infrastructure models and options for flexible and proactive capacity management
Workforce	
W.1.3	Integrate the needs of those living within the Framework into the wider Whaikaha [MSD] workforce plan to encourage tertiary education providers to adapt or develop dedicated training content and qualifications for a specialisation to work within the Framework
W.2.1	Develop a best practice 'safe staffing resourcing model' for all staff
Funding and Commissioning	
F.1.1	Establish commissioning processes in line with revised service specifications to ensure equity and consistency for all providers nationwide
F.1.2	Develop payment methods that better recognise the real cost of delivering care (including staffing, capital cost, maintenance, turnover) in a way that enables providers to plan ahead
F.2.1	Better manage capital investment and asset maintenance from a system perspective
F.2.2	Make capital funding available and accessible to service providers.

The current focus of MSD for the HCF is delivering the infrastructure response needed to deliver safe and secure RIDSS and RIDSAS facilities for those living under the HCF, alongside efforts to revise the commissioning approach and build workforce capability. This is directly related to the Environments and Infrastructure domain in the operational strategy.

The actions outlined in this section represent the range of dependencies between this investment and wider HCF system change.

Cross-Agency Partnership and Delivery Dependency

In addition to dependencies with wider system change, delivery of the investment outlined in this PBC is dependent on collaboration with other sector agencies and organisations with the capability and expertise required to deliver the infrastructure investment. To be successful this will require clear delineation of roles and responsibilities (discussed further in the Management Case) and the contractual mechanisms and considerations required to provide value for money and appropriate risk allocation (discussed in the Commercial Case). Careful relationship management and clear accountability will therefore be required to mitigate risks, ensure cross-agency alignment, and enable successful and timely delivery of the Programme of investment outlined in this PBC.

The relationship with Health New Zealand is crucial to the success of this investment, given RIDSS facilities are on hospital sites and therefore any development must align with infrastructure and investment master planning processes. Partnership with Health New Zealand is an enabler to the success of this programme, and as such, representatives have been involved at each stage of the development of this PBC, to provide input into the needs, feasibility and viability of RIDSS investment options. It will be essential for the ongoing partnership to continue through both the development and delivery of Detailed Business Cases (DBC), and Health New Zealand's representation on programme governance.

Understanding Required Capacity

The HCF system is dynamic, and the number of people receiving care under the HCF changes day to day depending on the nature of the cohort living under the HCF and their transitions into and out of services. Additionally, a lack of facility flexibility to accommodate different client cohorts and demographics leads to closing off beds and creates challenges in identifying the capacity required to support HCF clients. Given these challenges, the relatively small size of the HCF population (200-300 people) means standard demand modelling and forecasting methods are not applicable.

As such, the Options Development process outlined in this Business Case was predicated on the RIDSS Capacity Plan / Forecast outlined in the HCF Operational Strategy. The Capacity Plan / Forecast projections were informed by population-based benchmarking that considered the following:

- Client cohort characteristics
- Historic and planned use of beds across the region
- Understanding of critical capacity challenges (e.g. closing beds, inappropriate accommodation in wider forensic services) and cohort management practices
- Known challenges transitioning clients through the HCF system
- Supporting provision of care close to home and acknowledging the value of connection with whānau

These forecasts have therefore been used as a baseline to develop options and deliver sufficient flexible capacity throughout the HCF system.

3. Economic Case

3.1 Introduction

This Economic Case defines and assesses a longlist of options for nationwide investment in RIDSS Assessment, RIDSS secure, Stepdown and RIDSAS secure capacity that are designed to address the problems articulated in the Strategic Case. These options were assessed against the defined Investment Objectives and Critical Success Factors (CSFs) to identify Preferred Way(s) Forward that meet the needs of people living under the HCF and optimise value for money.

3.2 Scope

The scope of this Economic Case considers capital investment in RIDSS and secure RIDSAS facilities, either through the provision of purpose-built facilities or through refurbishment and renovation of existing facilities. Further scope details and assumptions are described below:

- All RIDSS services will be provided from a hospital site. This enables clients to receive specialised, holistic, and integrated care to address their needs (particularly where there may be comorbidities) in an environment that is more secure than can be achieved in a community setting.
- The focus of this business case is on RIDSS and secure RIDSAS facilities. Supervised RIDSAS facilities have not been considered within the scope of this Economic Case. Supervised RIDSAS facilities do not typically require the same level of environmental security features as secure RIDSAS or RIDSS facilities. This means that providers can more easily access the needed facilities on the property (rental) market; they do not require support to design, build, or access these facilities, and no shortage exists at this time. As such, supervised RIDSAS facilities have been excluded from capital investment consideration.
- Only secure RIDSAS facilities that have been assessed as suitable for retention, refurbishment to meet the SSM, or replacement on the existing site should be considered for new investment.

3.2.1 RIDSS Bed Capacity Plan

There are existing and forecast bed shortages across the network. The options in this Economic Case are based on meeting, to a greater or lesser extent, that demand, and reflect the forecasts completed by the Ministry of Health and updated by Whaikaha¹¹ which were included in the HCF Operational Strategy. These projections have been informed by population-based benchmarking that builds on the Forensic Bed Capacity Plan drafted by Sapere in 2021¹² and considers:

- Client cohort characteristics
- Historic and planned use of beds across the region
- Understanding of critical capacity challenges (e.g. bed blocking, inappropriate accommodation in wider forensic services) and cohort management practices
- Known challenges transitioning clients throughout the HCF system

¹¹ Note: The forecasts were updated when Whaikaha commissioned DSS and this responsibility has since shifted to MSD.

¹² While capacity pressures are increasing, the total demand in the system is relatively constant. Capacity projections will be confirmed in subsequent business cases.

- Supporting provision of care close to home and acknowledging the value of connection with whānau.

Table 10 summarises the RIDSS Bed Capacity Plan, including current state and forecast demand, by region.

Table 10: RIDSS Bed Capacity Plan/Forecast

Region	Current	Forecast	Change
Northern			
Assessment	2	4	+2
Secure	10	20	+5
Stepdown	-	4	+4
Midlands			
Assessment	1	2	+1
Secure	2	6	+4
Stepdown	-	-	-
Central			
Assessment	2	2	-
Secure	11	11	-
Stepdown	8	8	-
Southern – Upper (Canterbury)			
Assessment	1	2	+1
Secure	3	2	-1
Stepdown	-	-	-
Total – Upper Southern	4	4	-*
Southern – Lower (Dunedin)			
Assessment	1	2	+1
Secure	2	8	+6
Stepdown	4	4	-
Total – Lower Southern	7	14	+7
Southern – Total**			
Assessment	2	4	+2
Secure	5	10	+5
Stepdown	4	4	-
Total – Southern	11	18	+7
National Total	52	75	+23

* There is no functional difference between Secure beds and Assessment beds with respect to their design and features. Meeting the requirements set out in the Bed Capacity Plan therefore, only necessitates an operational change to the designation of the existing beds.

** In some instances, Options Development (and subsequent analysis) has collectively considered the Upper and Lower South to respond to requirements across the entire South Island. Practically, this means the required Lower Southern capacity may be met in the Upper Southern region and vice versa.

The complexity of the cohort makes modelling a challenge

Forecasting demand for the HCF is challenging due to the small cohort size, which paradoxically requires greater system flexibility. Eligibility for HCF care involves strict criteria and unpredictable events (i.e. criminal behaviour), making statistical analysis difficult. The population has evolved over time, and less than 20 years of data is available, complicating projections. System capacity itself is a limiting factor, with insufficient assessment beds and RIDSS capacity resulting in unmet demand. Regional population growth has not been matched by service provision, and the sensitivity of the system to small fluctuations in demand can result in operational bottlenecks when facilities operate near maximum capacity. Perversely, the relatively small

number of people in the system means that it is extremely sensitive to essentially random year-on-year shifts in demand. Facilities operating near maximum capacity means that small fluctuations in demand or the ability of people to move from RIDSS to RIDSAS facilities can create a lock-up of the system.

Following the Gate Review 0: Strategic Assessment, MSD has undertaken to work through a recommendation to further develop future cohort models as part of evidential support for future business cases and will keep these models under regular review as reform progresses.

3.2.2 RIDSAS Facilities

A range of RIDSAS facilities across New Zealand were assessed to understand their suitability for capital investment. Existing RIDSAS facilities are either owned or leased by providers and were not purpose-built. As a result, they often do not meet the needs of Care Recipients, whānau and staff. A small number of existing RIDSAS facilities can be appropriately renovated to meet the SSM and were considered for refurbishment or investment. **Table 11** describes the factors used to assess which existing facilities should receive investment and why these factors were important to consider.

Table 11: Factors used to assess the suitability of investment in RIDSAS facilities

Factor		Importance
Capacity	How many beds in the facility are contracted for Secure RIDSAS services?	RIDSAS facilities accommodate a range of secure, supervised, and civil clients from approximately 60 facilities nationwide.
Refurbishment requirements	What refurbishments would be required to meet the SSM? Is it possible to refurbish the facility to meet the SSM?	Only those RIDSAS facilities that can be refurbished to meet the SSM have been included in the longlist options. Some existing RIDSAS facilities cannot be refurbished to meet the SSM to support the provision of safe and least restrictive care and in these cases a new RIDSAS facility is proposed.
Cohort separation	Does the facility layout allow for cohort separation?	Cohort separation involves separating different genders, those with different needs, or those who have committed violent crimes from those who have not. Cohort separation is supported by the layout of RIDSAS facilities. If the facility does not allow for cohort separation, staff and client safety is at risk. When deciding whether to invest in a RIDSAS facility, only those facilities that currently support, or can be refurbished to support, cohort separation have been included in the longlist.
Location of facility	Is the facility in a rural or semi-rural location?	Rural or semi-rural RIDSAS facilities are preferred as they support least restrictive care and limit interface and sensitivity issues with local communities. Semi-rural facilities (as opposed to rural facilities) also allow for easier access to the workforce while still limiting issues with locating RIDSAS facilities in urban, populated areas.
Surrounding community features and facilities	Is the facility near any community facilities such as schools?	Secure RIDSAS facilities should not be located in close proximity to local schools or commonly used public spaces such as public pools. Many RIDSAS clients have a history of violent offending and should not reside in close proximity to these facilities.
Ownership	Who owns and/or operates the RIDSAS facility?	There is an emerging preference in disability for the government to own facilities for those in forensic, specialist care. This is for two reasons: the government has ultimate responsibility for people held under an Act and central ownership of the facilities can help maintain quality; the facilities also have little alternative use, and provider ownership can create lock-in for both the government and providers. For the purposes of this business case, it is assumed that there is a preference that (particularly new) facilities for RIDSS and RIDSAS secure care are government owned. RIDSAS supervised facilities can be owned by either the government or the provider. It is preferred that Care Providers either own the existing RIDSAS facilities or that a

long-term lease arrangement is in place. This provides confidence that the facility can continue to be contracted for RIDSAS use.

Extension ability	Could the facility be extended to increase capacity?	Depending on the existing facility condition, it may be suitable to extend a facility to increase the number of Secure RIDSAS beds provided. It is necessary to understand whether existing facilities can be extended based on the property size and condition, and whether the property is Crown-owned. Investing in the extension or renovation of a property on land that is not Crown-owned could present an unacceptable risk, given that the continued provision of services at that property is not guaranteed. This is discussed in more detail in the Strategic Case.
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Table 12 provides a summary of the RIDSAS facilities selected for inclusion in the longlist options based on their ability to fulfil the above criteria, with a key provided in **Table 13**. Refer to **Appendix F** for a more fulsome overview of the RIDSAS facilities.

Table 12: RIDSAS facilities selected for inclusion in the Longlist Options

RIDSAS Facility	Location	Region	# Beds	Ability to separate cohorts?	Owned / Leased by Provider?	Semi-Rural?	Candidate for refurbishment?
s9(2)(c)	Papakura	Northern	5	✓	✓	✗	✓
	Greenhithe	Northern	5	?	✓	✗	✓
	Hamilton	Midlands		?	✓	✓	✗
	Ōhaupō	Midlands	5	✓	✓	✓	✓
	Levin	Central	5	✓	✓	✓	✗
	Canterbury	Southern	6	?	✗ Crown-owned	✓	✓
	Canterbury	Southern	4	?	✗ Crown-owned	✓	✓
	Dunedin	Southern	4	✓	✓	✓	✓

Table 13: Key to Table 12

Yes	No	Unknown
✓	✗	?

It is assumed that RIDSAS facilities assessed as **not suitable** for investment are retained for other purposes and are no longer used to deliver RIDSAS secure care. They may be retained for other uses by providers, including RIDSAS supervised care, but this is outside the scope of this business case.

RIDSAS facilities assessed as **suitable** for investment will receive investment of some form in at least one of the longlist options. This Economic Case assumes that only those RIDSAS facilities and sites that receive investment (refurbishment or replacement with a new build) through the programme will be purchased by the

Crown to provide confidence that the facility will continue to be contracted for RIDSAS use following Crown investment. This assumption will be reviewed in subsequent DBCs.

3.2.3 RIDSS Capacity

Table 14 provides an overview of the existing RIDSS facilities across New Zealand and indicates whether a facility receives investment through this business case (refurbishment or replacement) under one or more of the longlist options and reflects the varying condition and suitability of existing facilities. Apart from the five beds currently borrowed from Forensic Mental Health in the Northern region, it is assumed that existing RIDSS facilities that do not receive investment under the longlist options are retained and continue to be used for Secure HCF services.

The RIDSS facilities that receive investment have either been identified as facilities that could be extended to provide the additional capacity required by the Bed Capacity Plan or are in poor condition and require investment to meet RIDSS quality expectations.

Table 14: RIDSS facilities/capacity that receive investment in at least one of the Longlist Options

RIDSS Facility	Region	Location	RIDSS Assessment Beds	RIDSS Secure Beds	Stepdown Beds	Receives investment under one or more of the longlist options?
RIDSS Unit	Northern	Auckland	2	10	-	X
Forensic Mental Health Capacity	Northern	Auckland	-	5	-	X
RIDSS Unit	Midlands	Waikato	1	2	-	✓
RIDSS Unit	Central	Wellington	2	11	8	X
RIDSS AT&R Unit	Upper Southern	Christchurch	1	3	-	✓
Ward 10A RIDSS	Lower Southern	Dunedin	1	2	-	✓
Stepdown Cottage	Lower Southern	Dunedin	-	-	4	✓

3.3 Options Development Overview

The following sections provide an overview of the longlist options development process, from the development of a set of initial Strategic Options to the development of twelve longlist options for investment in facilities across New Zealand.

Given the early stage of investment planning and the scope of HCF services across the country, a set of Strategic Options was developed to focus and prioritise investment according to facility type, quality level, and delivery strategy. These options prioritised RIDSS and RIDSAS investment relative to the needs of the HCF population, current state of the network and resources available to support the development of detailed options that best address the needs of the HCF population and network requirements.

Following the selection of a Preferred Strategic Option, a set of longlist options for RIDSS and RIDSAS facility investment was developed. The longlist options outlined the choices for RIDSS and RIDSAS facility investment across the Northern, Midlands, Central and Southern regions to reflect the strategic priorities and various design principles. These longlist options were then assessed against the Investment Objectives and CSFs to recommend Preferred Option/s for investment. This assessment process is outlined in Section 3.4

3.3.1 Strategic Options

This PBC has been developed at a time when the agencies that commission and provide the HCF are in the early stages of investment planning. To support integrated planning, this PBC considers investment in multiple services across the country. Given the number of variables (e.g. prioritisation, site locations, service type, facility typography, etc.), the first stage of the options development process included defining 'Strategic Options' to streamline and focus options development.

The Strategic Options were used to determine the overarching investment strategy and provided a way to consider and meet the different priorities for RIDSS and RIDSAS facilities. This enables a 'Whole of Network' approach to capacity and infrastructure investment to support consistent and integrated delivery of care across both RIDSS and RIDSAS facilities.

The Strategic Options were developed by considering three domains (Facility Type, Quality Level, Delivery Strategy) across which investment choices could be made for RIDSS and RIDSAS facilities, as illustrated in Figure 10.

Figure 10: Overview of the three domains guiding the development of the Strategic Options



The components within each domain were combined into different permutations to create an extensive range of Strategic Options for RIDSS and RIDSAS facilities. These combinations are presented in Table 16.

Table 15: Strategic Options for RIDSS and RIDSAS facilities

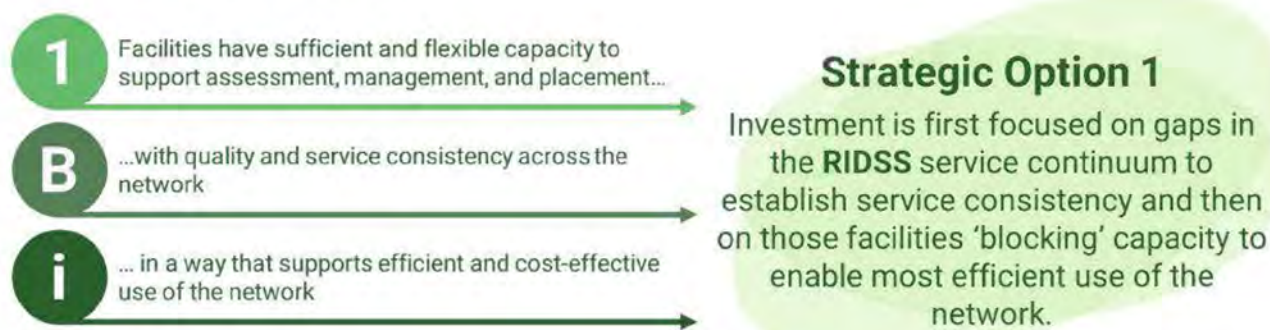
Option	Description
RIDSS Options	
1Ai	Investment is first focused on RIDSS facilities of the poorest quality in locations that best support the rehabilitative journey for the largest number of people.
1Aii	Investment is first focused on RIDSS facilities of the poorest quality in a way that makes the biggest difference to the largest number of people and / or creates network efficiencies while balancing capital requirements.
1Bi	Investment is first focused on gaps in the RIDSS service continuum to establish service consistency across the network in locations that best support the rehabilitative journey for the largest number of people.
1Bii	Investment is first focused on gaps in the RIDSS service continuum to establish service consistency and then on those facilities 'blocking' capacity to enable most efficient use of the network.
1Ci	Investment is first focused on RIDSS facilities with the aim of providing a homelike and therapeutic environment in locations that best support the rehabilitative journey for the largest number of people.
1Cii	Investment is first focused on RIDSS facilities with the aim of providing a homelike and therapeutic environment in a way that makes the biggest difference to the largest number of people and / or creates network efficiencies while balancing capital expenditure requirements.

Option	Description
RIDSAS Options	
2Ai	Investment is first focused on the poorest quality RIDSAS facilities in locations that best support the rehabilitative journey for the largest number of people.
2Aii	Investment is first focused on the poorest quality RIDSAS facilities in a way that makes the biggest difference to the largest number of people and / or creates network efficiencies while balancing capital requirements.
2Bi	Investment is first focused on RIDSAS facilities below a defined level of quality to provide uniform quality across the network in locations that best support the rehabilitative journey for the largest number of people.
2Bii	Investment is first focused on RIDSAS facilities below a defined level of quality to provide uniform quality across the network in a way that creates network efficiencies while balancing capital requirements.
2Ci	Investment is focused on building new RIDSAS facilities that are fit-for-purpose, robust and home-like, in locations that best support the rehabilitative journey for the largest number of people.
2Cii	Investment is focused on building new RIDSAS facilities that are fit-for-purpose, robust and home-like in a way that makes the largest difference to the largest number of people and / or creates network efficiencies while balancing capital requirements.

The preferred Strategic Options for RIDSS (1Bii) and RIDSAS facilities (2Ci) were decided during a workshop held on 15 February 2024 with key attendees from Whaikaha¹³, and subsequently presented and discussed with Health New Zealand.¹⁴

Under Strategic Option 1 (RIDSS, 1Bii), investment is first focused on gaps in the RIDSS Service Continuum to establish service consistency, and then on those facilities “blocking” capacity to enable the most efficient use of the network. **Figure 11** illustrates how the components within each domain combined to form Strategic Option 1.

Figure 11: Strategic Option 1 (RIDSS)



Strategic Option 1 (RIDSS, 1Bii) was selected because one of the most critical challenges across the HCF network is the lack of access to appropriate hospital-level Secure or Stepdown facilities. This lack of access has flow on implications for RIDSAS facilities and creates “bottlenecks” within the system. While RIDSS facilities are located within each region, some regions do not have sufficient RIDSS Secure capacity and others (perhaps more critically) do not have any available Stepdown capacity.

Investing in only the poorest RIDSS facilities and upgrading existing capacity (1Ai and 1Aii) would not address this critical challenge across the network. For example, most existing RIDSS facilities are in

¹³ Note that when the Strategic Options Workshop was held in February 2024, Whaikaha was responsible for commissioning disability support services and this responsibility has now transferred to MSD.

¹⁴ This meeting was held in June 2024.

reasonable condition, apart from Ward 10 at Dunedin Hospital. While investment in Dunedin would support an improved experience for Care Recipients in the region, it does not address the challenges associated with being unable to transition people through the HCF by utilising Stepdown capacity to release hospital level Secure capacity. Furthermore, upgrading existing facilities is unlikely to achieve the desired outcomes as the ability to address challenges associated with a facility that has not been purpose built by renovating or retrofitting is limited. For example, structural and spatial considerations may impede the ability to address line of sight challenges.

Under Strategic Option 2 (RIDSAS, 2Ci), investment is focused on building new RIDSAS facilities that are fit-for-purpose, robust and home-like, in locations that best support the rehabilitative journey for the largest number of people. **Figure 12** illustrates how the components within each domain combined to form Strategic Option 2.

Figure 12: Strategic Option 2 (RIDSAS)



Strategic Option 2 was selected because many existing RIDSAS facilities are not fit-for-purpose, meaning they do not meet the SSM, and do not reflect a homelike, therapeutic environment. This option would see the development of new, fit-for-purpose RIDSAS facilities in key locations to better support the rehabilitative journey for the largest number of people. In addition, existing RIDSAS facilities that can be refurbished would receive investment to better meet quality expectations and reflect a homelike environment. Refurbishing existing facilities will help to balance resource constraints while building new facilities where feasible. Finally, establishing RIDSAS facilities in every region will support HCF clients to move from hospital-based RIDSS care to community-based RIDSAS care, allowing capacity to flow through the system and further supporting the rehabilitative journey for the largest number of people.

The majority of RIDSAS facilities are in poor condition, and this means it is not possible to focus investment on only those facilities below a defined level of quality (2Bi and 2Bii), as the remaining RIDSAS facilities that are assessed as slightly above this defined level of quality will continue to provide care from facilities that are not fit-for-purpose. Focusing investment with the intent of making a difference to the largest number of people without reference to better supporting the rehabilitative journey (2Cii) does not align with the purpose of the care continuum, which is to support the rehabilitative journey from hospital-based RIDSS care to community-based RIDSAS care.

3.3.2 Longlist Options Development

Based on the direction described by the preferred Strategic Options, a set of eleven longlist options was developed for HCF investment in RIDSS and Secure RIDSAS facilities that reflect that strategic approach. The options reflect different design choices, including decentralisation, centralisation, minimisation of new build facilities, mixed new build and refurbished facilities, and the maximisation of new build facilities. Options development also considered whether the option meets the care continuum and/or the RIDSS Bed Capacity Plan. The design choices are explained in further detail below.

Table 16 provides a summary of the design principles driving each option, and outlines whether the option meets the care continuum and/or RIDSS Bed Capacity Plan requirements. More detail on the option design principles is provided in the sections below.

The HCF continuum represents the range of supports provided under the HCF from secure to secure (and more broadly supervised care, which is out of scope). While not all people in the HCF will go through all stages, many care recipients will transition from RIDSS to secure RIDSAS over their time in care. Some options that were considered provide this entire suite of supports, and some do not. An option is considered to meet the care continuum if it provides secure RIDSS, Stepdown, and secure RIDSAS capacity. If capacity at one of these care levels is not provided, then the option does not meet the care continuum.

Table 16: High-Level Overview of the Longlist Options

Option	Decentralised or Centralised?	Refurbishment or New Build Focus?	Meets the Care Continuum?	Meets RIDSS Capacity Requirement?
Option 1: Do Minimum	N/A	Focus on improving condition of existing facilities	Does not meet	Does not meet
Option 2: Refurbishment and Best Use of Existing Capacity	Decentralised	Best use of existing facilities and sites	Does not meet	Does not meet
Option 3: Meeting Secure Capacity Requirements	Decentralised	Repurpose existing inpatient capacity in Midlands, focus on new builds in Northern and Southern	Does not meet	Does not meet
Option 4: Care Continuum through New Build	Decentralised	Focus on providing new build facilities	Meets	Meets
Option 5: Care Continuum through Mixed New Build and Refurbishment	Decentralised	Combination of new builds and refurbishment	Meets	Meets
Option 6: Care Continuum with Refurbishment Focus	Decentralised	Focus on refurbishment of existing capacity	Meets	Meets
Option 7: RIDSS Centralisation	Centralised	Focus on building new build facilities	Does not meet	Meets
Option 8: RIDSS Centralisation – Minimise New Build	Centralised	Focus on refurbishment of existing facilities	Does not meet	Meets
Option 9: RIDSS Centralisation and RIDSAS Hubs	Centralised	Focus on RIDSS and RIDSAS centralised new builds	Does not meet	Meets
Option 10: RIDSS Centralisation and RIDSAS Hubs – Minimise New Builds	Centralised	Refurbishment of inpatient facilities, new build RIDSAS in each island	Does not meet	Meets
Option 11: Do Maximum	Decentralised	Focus on building new build capacity	Meets	Meets

As options development progressed, the differences between Option 4 and Option 5 were not as significant in practice as expected. The main differences between Option 4 and Option 5 are that Option 5 delivers an additional new build RIDSAS facility in the Midlands region, and an additional RIDSAS facility in the Southern region, while Option 4 delivers two additional Stepdown beds in the Upper Southern region. While Option 5 provides additional RIDSAS capacity, this capacity is not required to support the care continuum, and there is a sufficient number of end state RIDSAS beds provided under Option 4.

Decentralisation

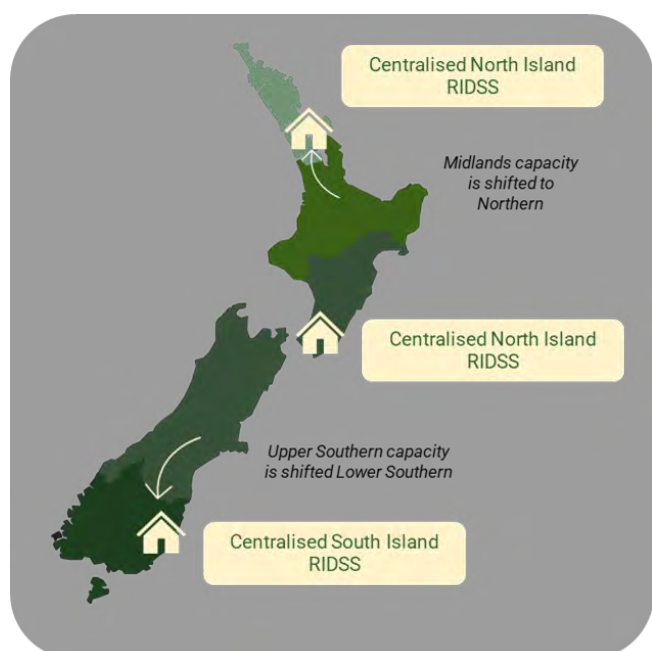
A set of longlist options was developed according to the principle of decentralisation in which investment is spread across all HCF regions (Northern, Midlands, Central, Upper Southern and Lower Southern) as required. In theory, this means HCF clients will have greater local access to HCF care across the care continuum if adequate capacity is provided. While a decentralised approach aligns with the capacity requirements outlined in the RIDSS Bed Capacity Plan, spreading capacity across the regions may limit economies of scale, and, practically, small units are both difficult to staff and deliver. The relatively small number of people requiring these services places a natural limit on the scale of decentralisation that is feasible, without significantly undermining efficiencies in staffing, resource, and capacity management across the North and South Islands.

In decentralised options, investment in Secure RIDSS and RIDSAS facilities is spread across all regions. However, the form of investment (refurbishment or replacement with a new facility) depends on the focus of the option, and the capacity provided depends on whether the option is focused on meeting the care continuum and/or the RIDSS Bed Capacity Plan requirements. For example, while both options are focused on investment in each region as required, **Option 3** is focused on meeting Secure capacity requirements, whereas **Option 4** is focused on meeting the care continuum.

Centralisation

A set of longlist options was developed according to the principle of RIDSS centralisation, which concentrates capacity in specific regions in the North and South Islands, as seen in **Figure 13**. This approach aims to provide greater efficiencies in staffing, resource, and capacity management for a future-proofed network. However, centralisation may also mean that clients and whānau have to travel further and more frequently either to access HCF services or to visit family members in HCF facilities located outside of their home region. This issue could be addressed through increased travel and accommodation allowances which

Figure 13: Impact of Centralisation in the North and South Islands



could prove to be more efficient than providing more in-region capacity, particularly given the relatively small number of clients.

For example, **Option 7** is focused on building new RIDSS Secure facilities in the Northern region and Lower Southern region. This means Midlands Secure RIDSS clients would have to travel to Auckland (Northern region) and Upper Southern Secure RIDSS clients would have to travel to Dunedin (Lower Southern region) to receive care. The centralisation of Secure RIDSS facilities aims to enable greater efficiencies in capacity management and a future-proofed network.

In centralisation options, an option might not meet the RIDSS Bed Capacity Plan in every region, but sufficient capacity will be provided across the network overall. For example, in **Option 7**, there is no investment in Midlands RIDSS capacity, and the existing facility does not continue to be used for Secure service delivery. The additional capacity required by the RIDSS Bed Capacity Plan in the Midlands region is provided by investment in Northern RIDSS capacity, and the Northern facility has enough capacity to deliver Secure services and 'replace' the capacity provided by the existing Midlands facility that is retained but does not continue to be used for Secure HCF purposes.

Within the suite of centralised options, the form of investment (refurbishment of existing facilities versus building new facilities) and the extent of investment (the number of facilities receiving investment) vary. Like the decentralised options, this depends on whether the option is focused on meeting the care continuum and/or the RIDSS additional capacity requirements according to the Bed Capacity Plan. For example, **Option 8** focuses on RIDSS centralisation in the North and South Islands. While this investment strategy has similarities to the RIDSS centralisation in **Option 7**, **Option 8** focuses on minimising the number of new facilities built to achieve centralisation. This means that in the Lower Southern region, the existing 3-bed RIDSS facility (Ward 10A) is refurbished to increase RIDSS capacity in the Southern region. However, in **Option 7**, a new 14-bed facility is built in the Lower Southern region to replace the existing RIDSS facility.

Minimise New Build

A set of longlist options was developed to minimise the number of new build facilities, which means there is a larger focus on refurbishing existing facilities. For example, **Option 2** is focused on making the best use of existing facilities where possible or redeveloping existing sites where the land is owned by the Crown. In this option, the Ward 10A RIDSS facility is refurbished, and the vacated mental health capacity is used to increase the number of RIDSS beds.

Meeting the Care Continuum

A set of longlist options was developed to meet the HCF care continuum. Meeting the care continuum means that RIDSS Assessment, RIDSS Secure, Stepdown and RIDSAS Secure capacity is provided in every region. Providing capacity across the continuum allows HCF clients to transition from high security environments to community care and supports the provision of the least restrictive care. The capacity provided by the longlist options was also developed to be flexible to the needs of the youth cohort.

Meeting the RIDSS Bed Capacity Plan

Options development has been guided by the RIDSS Bed Capacity Plan from the HCF Operational Strategy. While options have been developed to provide additional capacity according to the plan, options that focus on minimising the investment required to meet critical concerns do not meet the RIDSS Bed Capacity Plan.

3.3.3 Key Features of the Longlist Options

An overview of the key features of, and capacity provided by, the longlist options is provided in Table 17 below. The table describes RIDSS and RIDSAS facility intervention in each option according to the following criteria:

- **Retention of Existing RIDSS/RIDSAS Facility with no investment:** Many existing RIDSS and/or RIDSAS facilities are retained for use with no investment. While this is not a change to the status quo, it is not assumed that every existing facility continues to be used to provide HCF services. If an existing RIDSS/RIDSAS facility is not mentioned in the table, the facility is not retained to deliver Secure RIDSS and RIDSAS services and is used for other purposes.
- **Provision of New Build Facility:** The table outlines when a new, fit-for-purpose RIDSS and/or RIDSAS facilities is constructed. These new facilities either replace existing capacity with the aim of providing better quality facilities or provide additional new capacity. When an existing facility's capacity is 'replaced', the existing facility does not continue to provide Secure HCF services, but can still be used for other purposes.
- **Refurbishment of Existing Facility:** The table outlines when an existing RIDSS or RIDSAS facility is refurbished to meet Secure service expectations.

According to this criterion, the table provides a summary of:

- **Purpose of the Option:** What the Option was developed to achieve in terms of meeting the care continuum, meeting the RIDSS Bed Capacity Plan, decentralisation, centralisation, or to minimise or maximise new builds.
- **Investment provided by Facility:** Whether the option retains, refurbishes, or replaces an existing RIDSS/RIDSAS facility with a new build (on the existing site or a new site), or whether it provides additional capacity on a new site through a new build facility.
- **Total End State Beds:** The total number of end state RIDSS and RIDSAS beds provided by the option, including beds that do not receive investment under the given option but are retained for RIDSS/RIDSAS use.

A more detailed version of this table is provided in Appendix G, and detailed one-page overviews of each longlist option are provided in Appendix H.

Table 17: Key Features of the Longlist Options

Feature		Option 1: Do Minimum	Option 2: Refurbishment and Best Use of Existing Capacity	Option 3: Meeting Secure Capacity Requirements	Option 4: Care Continuum through New Build	Option 5: Care Continuum through Mixed New Build and Refurbishment	Option 6: Care Continuum with Refurbishment Focus	Option 7: RIDSS Centralisation	Option 8: RIDSS Centralisation – Minimise New Build	Option 9: RIDSS Centralisation and RIDSAS Hubs	Option 10: RIDSS Centralisation and RIDSAS Hubs – Minimise New Build	Option 11: Do Maximum
Purpose		The 'Do Minimum' option focuses on providing the minimum level of investment required to address critical concerns across the HCF network. Investment is focused on providing needed Secure capacity in key regions and improving existing facility condition in targeted areas.	This option focuses on meeting capacity requirements by making best use of existing facilities where possible, or redeveloping existing sites where land is owned. Given uncertainty regarding the Midlands Site Master Plan (SMP), only minor refurbishments are proposed until more is known about the long-term future of the site.	Investment to provide additional Secure capacity where required in each region. This is predominantly achieved through new build facilities in the Northern and Southern regions and repurposing existing inpatient capacity in Midlands to provide additional Secure RIDSS capacity (noting this is dependent on the Site Master Plan).	Investment focused on providing the care continuum within each region, predominantly through provision of new build facilities across all regions where there are gaps.	Investment focused on providing the care continuum within each region, through a combination of new builds and the refurbishment of existing capacity (primarily regarding RIDSS options in the Southern region.) <i>Note: Option 5 was discarded from the assessment process because it is too similar to Option 4.</i>	Investment focused on providing the care continuum within each region, predominantly through the refurbishment of existing capacity (primarily regarding RIDSS options in the Southern region.)	Investment is focused on centralising RIDSS capacity in the North Island and South Island through building of new, fit for purpose facilities. This aims to enable greater efficiencies in capacity management and a future-proofed network.	Centralised RIDSS capacity is realised primarily through the refurbishment of existing facilities, to provide a potentially more cost-effective solution.	Capacity is managed flexibly nationwide, across regions, by building new capacity in both RIDSS centralised locations, supported by a new build RIDSAS facility 'hub' in each island.	Provision of care is centralised where possible in the North and South Islands to support streamlined access to care and greater workforce efficiencies. Where possible, inpatient capacity is repurposed / refurbished to make the best use of existing facilities. New build RIDSAS facilities are provided in semi-rural settings to create community care "hubs".	The 'Do Maximum' option maximises investment in new, fit-for-purpose facilities to meet bed capacity plan requirements and provide access to the care continuum within each region. This option has the most new build capacity.
What does this Option Achieve?¹⁵		Option 1	Option 2	Option 3	Option 4	Option 5	Option 6	Option 7	Option 8	Option 9	Option 10	Option 11
Refurbished or New Build Capacity?												
Decentralised or Centralised?												
Care Continuum Achieved?												
RIDSS Capacity Achieved?												
Intervention by Facility		Option 1	Option 2	Option 3	Option 4	Option 5	Option 6	Option 7	Option 8	Option 9	Option 10	Option 11
KEY Gold = New facilities Silver = Refurbished facilities	Northern											
	Existing RIDSS Capacity 2 Assessment 10 Secure	Retain existing capacity, no investment, continue to use for HCF	Retain existing capacity, no investment, continue to use for HCF	Retain existing capacity, no investment, continue to use for HCF	Retain existing capacity, no investment, continue to use for HCF	Retain existing capacity, no investment, continue to use for HCF	Retain existing capacity, no investment, continue to use for HCF	Retain existing capacity, no investment, continue to use for HCF	Retain existing capacity, no investment, continue to use for HCF	Retain existing capacity, no investment, continue to use for HCF	Retain existing capacity, no investment, continue to use for HCF	Retain existing capacity, no investment, continue to use for HCF
	Borrowed Forensic Mental Health Capacity 5 Secure	No longer used	No longer used	No longer used	No longer used	No longer used	No longer used	No longer used	No longer used	No longer used	No longer used	No longer used
	New RIDSS	New 10-bed RIDSS and Stepdown	New 12-bed RIDSS	New 12-bed RIDSS	New 12-bed RIDSS New 4-bed Stepdown	New 12-bed RIDSS New 4-bed Stepdown	New 12-bed RIDSS New 4-bed Stepdown	New 10-bed RIDSS New 10-bed RIDSS New 4-bed Stepdown	New 10-bed RIDSS New 10-bed RIDSS New 4-bed Stepdown	New 10-bed RIDSS New 10-bed RIDSS New 4-bed Stepdown	New 10-bed RIDSS New 10-bed RIDSS New 4-bed Stepdown	New 12-bed RIDSS New 4-bed Stepdown
	S9(2)(c) RIDSAS 5 RIDSAS	Refurbish to meet SSM	Refurbish to meet SSM	Refurbish to meet SSM	Refurbish to meet SSM	Refurbish to meet SSM	Refurbish to meet SSM	Refurbish to meet SSM	Refurbish to meet SSM	Refurbish to meet SSM	Refurbish to meet SSM	Refurbish to meet SSM
	2A Ashby RIDSAS 5 RIDSAS	Retain, no investment, continue to use for HCF	Retain, no investment, continue to use for HCF	Retain, no investment, continue to use for HCF	Retain, no investment, continue to use for HCF	Retain, no investment, continue to use for HCF	Retain, no investment, continue to use for HCF	Replace capacity with new 5-bed RIDSAS	Retain, no investment, continue to use for HCF	Replace capacity with new 5-bed RIDSAS	Replace capacity with new 5-bed RIDSAS	Replace capacity with new 5-bed RIDSAS
KEY Gold = New facilities Silver = Refurbished facilities	Midlands											
	RIDSS Unit 1 Assessment 2 Secure	Retain, no investment, continue to use for HCF	Refurbish existing facility	Refurbish existing 3-bed and add capacity from vacated Mental Health	Replace with new 10-bed facility	Refurbish existing 3-bed and add capacity from vacated Mental Health	Refurbish existing 3-bed and add capacity from vacated Mental Health	Replace capacity in new Northern facilities. Retain existing facility but no longer use for HCF services.	Replace capacity in new Northern facilities. Retain existing facility but no longer use for HCF services.	Replace capacity in new Northern facilities. Retain existing facility but no longer use for HCF services.	Replace capacity in new Northern facilities. Retain existing facility but no longer use for HCF services.	Replace capacity with new 10-bed RIDSS facility
	S9(2)(c) RIDSAS 5 RIDSAS	Retain, no investment, continue to use for HCF	Minor refurbishment to meet SSM	Minor refurbishment to meet SSM	Minor refurbishment to meet SSM	Minor refurbishment to meet SSM	Minor refurbishment to meet SSM	Minor refurbishment to meet SSM	Minor refurbishment to meet SSM	Minor refurbishment to meet SSM	Minor refurbishment to meet SSM	Minor refurbishment to meet SSM
	S9(2)(c) RIDSAS 5 RIDSAS	No investment, not used for Secure capacity	Demolish facility and replace capacity with new 5-bed RIDSAS	Demolish facility and replace capacity with new 5-bed RIDSAS	Demolish facility and replace capacity with new 5-bed RIDSAS	Demolish facility and replace capacity with new 5-bed RIDSAS	Demolish facility and replace capacity with new 5-bed RIDSAS	Demolish facility and replace capacity with new 5-bed RIDSAS	Demolish facility and replace capacity with new 5-bed RIDSAS	Demolish facility and replace capacity with new 5-bed RIDSAS	Demolish facility and replace capacity with new 5-bed RIDSAS	Demolish facility and replace capacity with new 5-bed RIDSAS
KEY	Central											
	Existing RIDSS Capacity 2 Assessment 11 Secure 8 Stepdown	Retain existing capacity, no investment, continue to use for HCF	Retain existing capacity, no investment, continue to use for HCF	Retain existing capacity, no investment, continue to use for HCF	Retain existing capacity, no investment, continue to use for HCF	Retain existing capacity, no investment, continue to use for HCF	Retain existing capacity, no investment, continue to use for HCF	Retain existing capacity, no investment, continue to use for HCF	Retain existing capacity, no investment, continue to use for HCF	Retain existing capacity, no investment, continue to use for HCF	Retain existing capacity, no investment, continue to use for HCF	Retain existing capacity, no investment, continue to use for HCF

¹⁵ This section of the table depicts the extent to which an option achieves each factor on a spectrum. For example, for 'Refurbished or New Build Capacity' the lefthand side of the spectrum represents options with a higher proportion of refurbished facilities, while the righthand side of the spectrum represents options with a higher proportion of new build facilities.

Feature		Option 1: Do Minimum	Option 2: Refurbishment and Best Use of Existing Capacity	Option 3: Meeting Secure Capacity Requirements	Option 4: Care Continuum through New Build	Option 5: Care Continuum through Mixed New Build and Refurbishment	Option 6: Care Continuum with Refurbishment Focus	Option 7: RIDSS Centralisation	Option 8: RIDSS Centralisation – Minimise New Build	Option 9: RIDSS Centralisation and RIDSAS Hubs	Option 10: RIDSS Centralisation and RIDSAS Hubs – Minimise New Build	Option 11: Do Maximum
Gold = New facilities Blue = Refurbished facilities	s9(2)(c) Replacement RIDSAS 5 RIDSAS	No investment, continue to use for HCF	Replace capacity with new 5-bed RIDSAS	Replace capacity with new 5-bed RIDSAS	Replace capacity with new 5-bed RIDSAS	Replace capacity with new 5-bed RIDSAS	Replace capacity with new 5-bed RIDSAS	Replace capacity with new 5-bed RIDSAS	Replace capacity with new 5-bed RIDSAS	Replace capacity with new 5-bed RIDSAS	Replace capacity with new 5-bed RIDSAS	Replace capacity with new 5-bed RIDSAS
	New RIDSAS									New 4-bed RIDSAS		New 4-bed RIDSAS
		New 5-bed RIDSAS	New 5-bed RIDSAS	New 5-bed RIDSAS	New 5-bed RIDSAS	New 5-bed RIDSAS	New 5-bed RIDSAS	New 5-bed RIDSAS	New 5-bed RIDSAS	New 5-bed RIDSAS	New 5-bed RIDSAS	New 5-bed RIDSAS
Upper Southern (Christchurch)	New RIDSS				New 4-bed Stepdown	New 2-bed Stepdown						New 2-bed Stepdown
KEY Gold = New facilities Blue = Refurbished facilities	RIDSS AT&R Unit 1 Assessment 3 Secure	Retain as is, continue to use for HCF	Retain as is, continue to use for HCF	Retain as is, continue to use for HCF	Retain as is, continue to use for HCF	Retain as is, continue to use for HCF	Refurbish existing and add 5 new beds	Retain, as is, do not continue to use for HCF	Retain, as is, do not continue to use for HCF	Retain, as is, do not continue to use for HCF	Retain, as is, do not continue to use for HCF	Retain, as is, do not continue to use for HCF
	s9(2)(c) RIDSAS 4 RIDSAS	Refurbish to meet SSM	Refurbish to meet SSM	Refurbish to meet SSM	Replace capacity with new 4-bed RIDSAS	Replace capacity with new 4-bed RIDSAS	Refurbish to meet SSM	Refurbish to meet SSM	No investment, not used for Secure capacity	Replace capacity with new 4-bed RIDSAS	Refurbish to meet SSM	Replace capacity with new 4-bed RIDSAS
	s9(2)(c) RIDSAS 6 RIDSAS	Refurbish to meet SSM	Refurbish to meet SSM	Refurbish to meet SSM	Refurbish to meet SSM	Refurbish to meet SSM	Refurbish to meet SSM	No investment, not used for Secure capacity	Refurbish to meet SSM	Refurbish to meet SSM	Refurbish to meet SSM	Replace capacity with new 5-bed facility
Lower Southern (Dunedin)	Ward 10A RIDSS 1 Assessment 2 Secure	Continue planned refurbishments (Outside PBC Scope)	Refurbish and use vacated capacity to increase RIDSS capacity	Replace capacity with new 10-bed RIDSS	Replace capacity with new 10-bed RIDSS	Replace capacity with new 10-bed RIDSS	Refurbish existing RIDSS and add 5 new beds	Replace capacity with new 14-bed RIDSS	Refurbish and build new RIDSS capacity (8-bed facility)	Replace capacity with new 14-bed RIDSS	Refurbish and add new RIDSS capacity (8-bed facility)	Replace capacity with new 10-bed RIDSS
KEY Gold = New facilities Blue = Refurbished facilities	New RIDSS								New 6-bed RIDSS* (noting that there may be options to build elsewhere)		New 6-bed RIDSS* (noting that there may be options to build elsewhere)	
	Stepdown Cottage 4 Stepdown	Refurbish to meet SSM	Refurbish to meet SSM	Refurbish to meet SSM	Refurbish to meet SSM	Refurbish to meet SSM	Refurbish to meet SSM	Refurbish to meet SSM	Refurbish to meet SSM	Refurbish to meet SSM	Refurbish to meet SSM	Refurbish to meet SSM
	s9(2)(c) RIDSAS 4 RIDSAS	Refurbish to meet SSM	Refurbish to meet SSM	Refurbish to meet SSM	Replace capacity with new 4-bed facility	Replace capacity with new 4-bed facility	Refurbish to meet SSM	Replace capacity with new 5-bed RIDSAS	Refurbish to meet SSM	Replace capacity with new 4-bed RIDSAS	Refurbish to meet SSM	Replace capacity with new 5-bed RIDSAS
	New RIDSAS		New 4-bed RIDSAS	New 4-bed RIDSAS		New 4-bed RIDSAS	New 4-bed RIDSAS	New 5-bed RIDSAS	New 5-bed RIDSAS	New 5-bed RIDSAS	New 5-bed RIDSAS	New 5-bed RIDSAS
Total New RIDSS Beds Provided (Additional to existing facility capacity)												
KEY Red = does not meet Bed Capacity Plan Green = meets Bed Capacity Plan Yellow = beds provided surplus to Bed Capacity Plan		Option 1	Option 2	Option 3	Option 4	Option 5	Option 6	Option 7	Option 8	Option 9	Option 10	Option 11
Northern	RIDSS Assessment [+2]	+0	+2	+2	+2	+2	+2	+3	+3	+3	+3	+2
	RIDSS Secure [+5]	+1	+5	+5	+5	+5	+5	+9	+9	+9	+9	+5
	Stepdown [+4]	+4	+0	+0	+4	+4	+4	+4	+4	+4	+4	+4
Midlands	RIDSS Assessment [+1]	+0	+0	+1	+1	+1	+1	Met by Northern	Met by Northern	Met by Northern	Met by Northern	+1
	RIDSS Secure [+4]	+0	+0	+4	+4	+4	+4	Met by Northern	Met by Northern	Met by Northern	Met by Northern	+4
	Stepdown [+0]	+0	+0	+0	+2	+2	+2	+0	+0	+0	+0	+2
Central	RIDSS Assessment [+0]	+0	+0	+0	+0	+0	+0	+0	+0	+0	+0	+0
	RIDSS Secure [+0]	+0	+0	+0	+0	+0	+0	+0	+0	+0	+0	+0
	Stepdown [+0]	+0	+0	+0	+0	+0	+0	+0	+0	+0	+0	+0
Southern	RIDSS Assessment [+1] ¹⁶	+0	+1	+1	+1	+1	+1	+1	+1	+1	+1	+1
	RIDSS Secure [+6]	+0	+4	+6	+6	+6	+6	+6	+6	+6	+6	+6
	Stepdown [+0]	+0	0	0	+4	+2	+2	0	0	0	0	+2
Total End State Beds [] = Number of Existing Beds		Option 1	Option 2	Option 3	Option 4	Option 5	Option 6	Option 7	Option 8	Option 9	Option 10	Option 11
Northern	RIDSS Assessment [2]	2	4	4	4	4	4	6	6	6	6	4
	RIDSS Secure [15]	16	20	20	20	20	20	26	26	24	24	20
	Stepdown [0]	4	0	0	4	4	4	4	4	4	4	4
	RIDSAS	15	15	15	15	15	15	18	18	10	10	18
Midlands	RIDSS Assessment [1]	1	1	2	2	2	2	Moved to Northern	Moved to Northern	Moved to Northern	Moved to Northern	2
	RIDSS Secure [2]	2	2	6	6	6	6	Moved to Northern	Moved to Northern	Moved to Northern	Moved to Northern	6
	Stepdown [0]	0	0	0	2	2	2	0	0	0	0	2
	RIDSAS	5	10	14	10	15	15	10	10	18	14	14
Central	RIDSS Assessment [2]	2	2	2	2	2	2	2	2	2	2	2
	RIDSS Secure [11]	11	11	11	11	11	11	11	11	11	11	11
	Stepdown [8]	8	8	8	8	8	8	8	8	8	8	8
	RIDSAS	10	10	10	10	10	10	10	10	14	10	14
Southern	RIDSS Assessment [1]	2	3	3	3	3	3	3	5	3	3	3

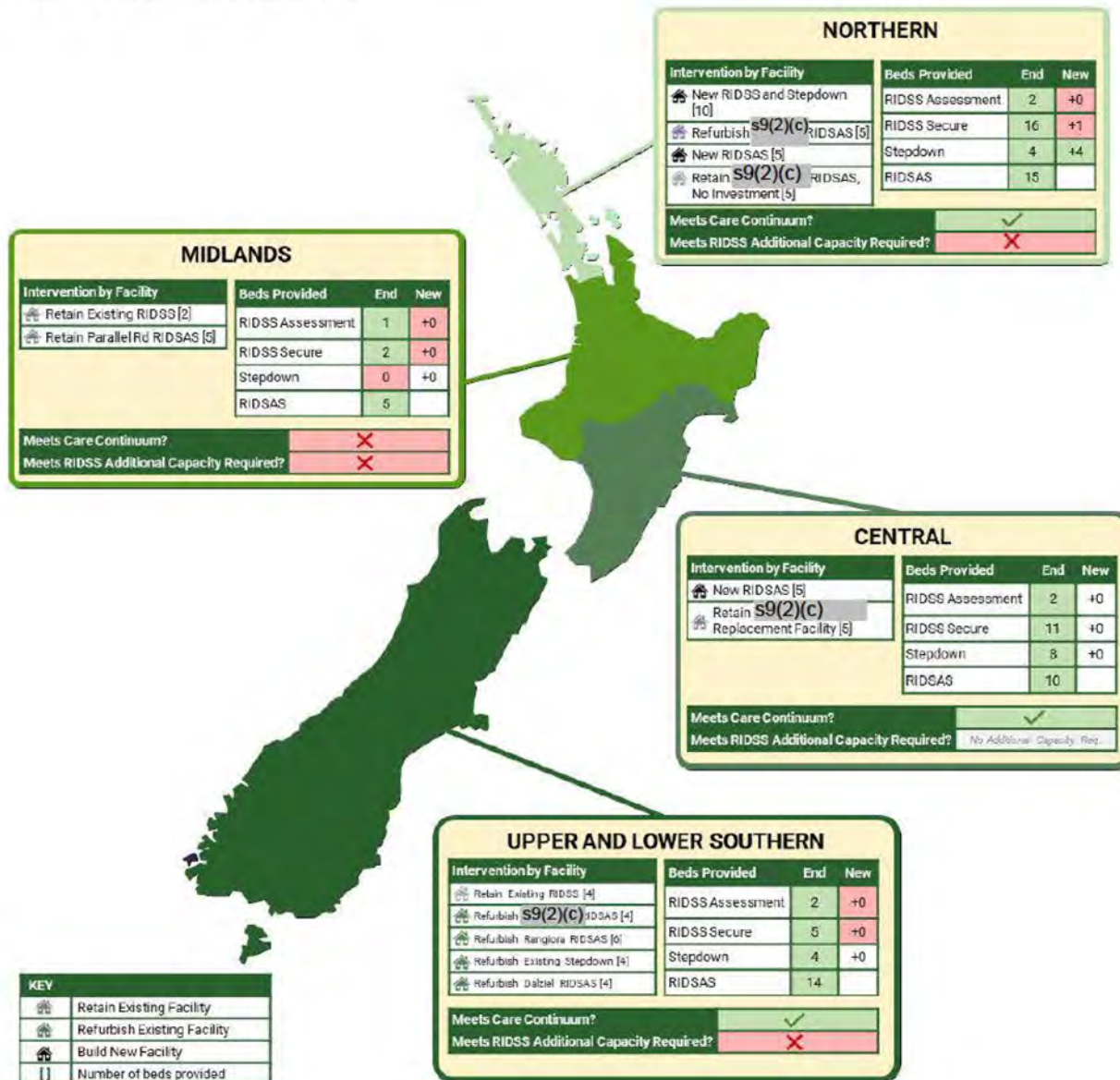
¹⁶ Note that the RIDSS Bed Capacity Plan states that one additional assessment bed is required in the Upper Southern region, but one less Secure bed is required. This capacity requirement can be met by using an existing Secure bed as an assessment bed and no additional capacity is required through the options for investment. For the purpose of this analysis, the additional capacity requirement is depicted as +0.

Feature		Option 1: Do Minimum	Option 2: Refurbishment and Best Use of Existing Capacity	Option 3: Meeting Secure Capacity Requirements	Option 4: Care Continuum through New Build	Option 5: Care Continuum through Mixed New Build and Refurbishment	Option 6: Care Continuum with Refurbishment Focus	Option 7: RIDSS Centralisation	Option 8: RIDSS Centralisation – Minimise New Build	Option 9: RIDSS Centralisation and RIDSAS Hubs	Option 10: RIDSS Centralisation and RIDSAS Hubs – Minimise New Build	Option 11: Do Maximum
	RIDSS Secure [3]	5	9	11	11	11	11	11	13	11	11	11
	Stepdown [0]	4	4	4	8	6	6	4	4	4	4	6
	RIDSAS	14	18	18	14	18	18	14	15	19	19	19

3.3.4 The Do Minimum

The 'Do Minimum' option represents the minimum investment needed to address critical concerns across the HCF network. Investment is focused on providing needed Secure capacity in key regions and improving existing facility conditions in targeted areas. Due to the criticality of HCF investment, there is no acceptable 'Do Nothing' scenario. **Figure 14** illustrates investment across all regions under Option 1: Do Minimum.

Figure 14: Option 1: Do Minimum



Option 1 does not meet the current and future capacity requirements outlined in the RIDSS Bed Capacity Plan and does not meet the care continuum. Addressing only those concerns regarded as "critical" is a temporary fix that addresses the immediate issues but does not provide an acceptable long-term solution.

The Do Minimum **addresses** the following critical (short-term) network concerns:

- **Provides required Northern Stepdown capacity:** Option 1 provides 4 additional new Stepdown beds through a new 10-bed RIDSS facility. This additional Stepdown capacity supports the transition of HCF clients from hospital-based to community-based care, helping to prevent capacity blockages in the rehabilitative care journey.
- **Replaces Northern RIDSS beds borrowed from Forensic Mental Health:** Option 1 provides six new Secure beds through a new 10-bed RIDSS facility. Five of the new beds will replace the five beds

currently borrowed from Forensic Mental Health which will no longer be available for HCF use in the near future.

- **Refurbishes existing RIDSAS facilities in Northern and Southern regions to meet the SSM:** Option 1 refurbishes the s9(2)(c) RIDSAS facility (Northern region) and the s9(2)(c), s9(2)(c), and s9(2)(c) RIDSAS facilities (Southern region) to meet the SSM. This will increase the quality of RIDSAS facilities in these regions, supporting staff to provide higher quality and safer care.
- **Provides new build RIDSAS facilities in the Northern and Central regions:** Option 1 provides new 5-bed RIDSAS facilities in the Northern and Central regions. In the Central region, the new facility replaces the existing s9(2)(c) RIDSAS capacity which has issues that cannot be remediated through refurbishment.

The Do Minimum **does not address** the following long-term network concerns:

- **Remedy the unacceptable condition of Dunedin's Ward 10A (RIDSS facility)**¹⁷: Option 1 retains Ward 10A for RIDSS use with no investment. Ward 10A is in unacceptable condition and requires significant refurbishment (minimum acceptable solution) or replacement (acceptable long-term solution) to meet RIDSS quality expectations. The ward lacks the required layout to separate HCF clients (creating significant safety concerns), lacks natural light, and has no separate communal areas. Option 1 retains Ward 10A with the assumption that planned refurbishments outside the scope of this PBC will proceed.
- **Remedy the unacceptable condition of Midland's existing RIDSS facility:** The Midlands RIDSS facility requires refurbishment to meet quality expectations. The existing facility lacks appropriate spaces to manage complex cohorts and support the provision of the least restrictive environments.
- **Provide additional (new) capacity to meet the RIDSS Bed Capacity Plan:** Option 1 does not meet the capacity requirements outlined in the Bed Capacity Plan in any region that requires additional capacity (Northern, Midlands, and Southern regions).
- **Refurbish all retained RIDSAS facilities to meet the SSM:** Option 1 retains two RIDSAS facilities (s9(2)(c) and the s9(2)(c) replacement) for ongoing use with no investment. This means these RIDSAS facilities will not meet the SSM, and RIDSAS facility quality will vary across the country, providing an inconsistent standard of care and security and putting RIDSAS clients and staff at unnecessary risk.

3.4 Longlist Options Assessment

A series of workshops was held in April and May 2024 to assess the longlist options against the Investment Objectives and CSFs. These workshops included key stakeholders from Whaikaha.¹⁸ External stakeholders also provided written commentary on, and an assessment of, the longlist options.

A three-stage qualitative assessment was used to assess the longlist options and included:

- **Investment Objective Assessment:** This stage acts as a gate to test whether each option can deliver on the objectives of the business case.
- **CSF Stage 1 Assessment:** To assess which option is expected to achieve or contribute to each of the respective Stage 1 CSFs. This assessment is used to select an options shortlist.
- **CSF Stage 2 Assessment:** This Stage 2 Assessment is used to select a Preferred Way(s) Forward from the options shortlist based on the following criteria: Time, Service Continuity, and Affordability.

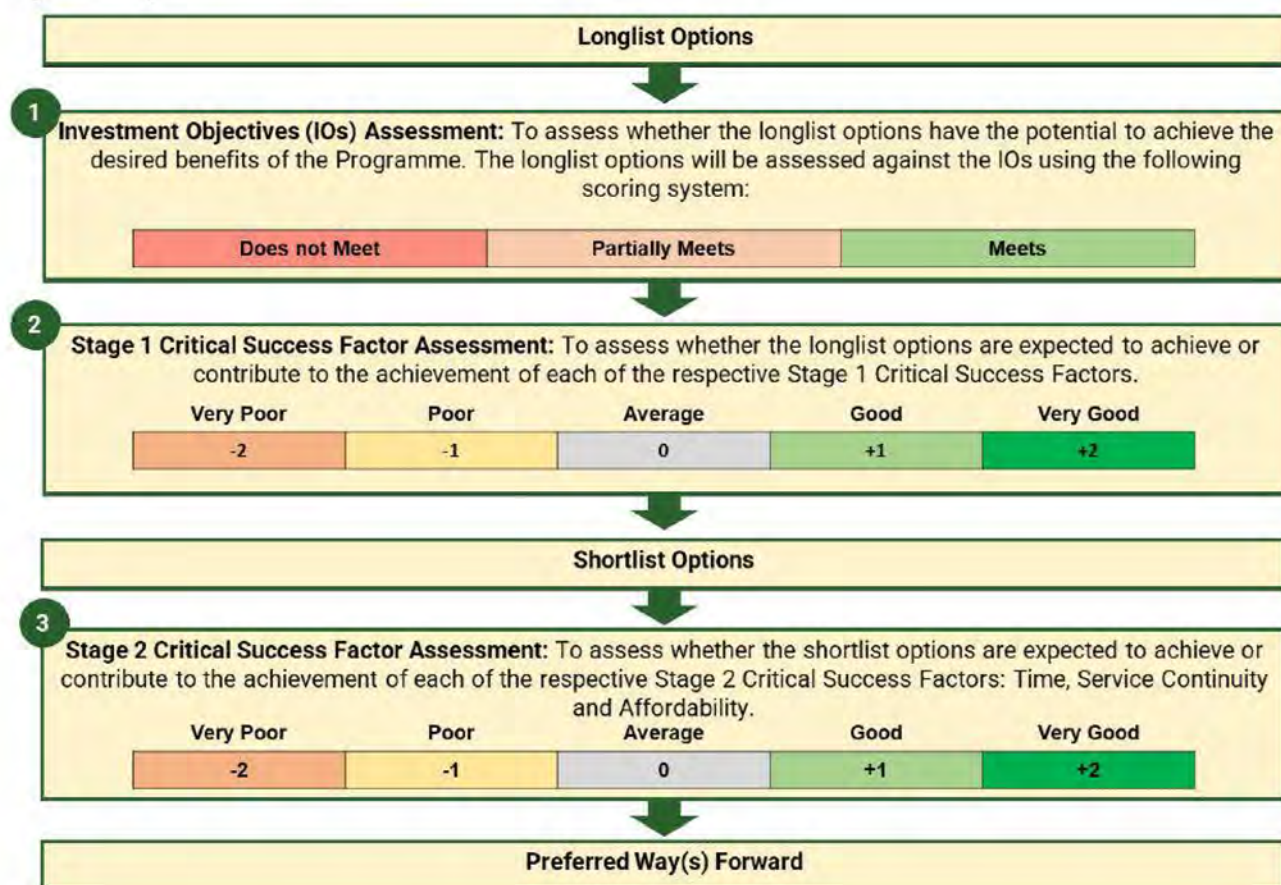
¹⁷ The unacceptable condition of Ward 10A is not remedied by, and the infrastructure is unrelated to, the Dunedin Hospital Rebuild.

¹⁸ Note that when this workshop was held, Whaikaha was responsible for commissioning disability support services and this responsibility has now transferred to MSD.

This assessment is informed by information on the phasing, programming and Whole of Life Cost (WOLC) of the shortlist options. Only the shortlisted options that passed the Stage 1 Assessment were programmed and costed.

The options assessment process is illustrated in **Figure 15** below.

Figure 15: Options Assessment Framework Overview



3.4.1 Investment Objective Assessment Overview

The longlist options were assessed against the Investment Objectives presented in the Strategic Case. Investment Objectives specify desired outcomes for investment in HCF Secure services and are used to assess each longlist option against how well it achieves the desired vision for the HCF. The Investment Objectives are outlined in **Table 18** below.

Table 18: Investment Objectives

Investment Objective	Description
1 Sufficient flexible capacity to manage clients and meet demand	HCF facilities respond flexibly to changes in demand and the increasing complexity of care requirements. The physical environment enables separation between cohorts or individuals as necessary, without compromising the provision of care.
2 Facilities are robust, appropriate to the cohort, and homelike	HCF facilities are fit-for-purpose with furnishings and fittings that are high quality to maintain good condition. They accommodate the needs of the clients by providing safe, therapeutic, and homelike environments for rehabilitative care.
3 Facilities provide a safe, secure environment for staff and clients	HCF facilities have features which enable care to be provided safely and securely to clients, whilst protecting staff and minimising complicated operational practices. Clients receive the levels of independence and freedom they are entitled to.
4 Facilities protect public safety	HCF facilities are of an appropriate level of quality and have the security elements required to minimise abscondments and unplanned or unsafe interactions with the public.

Each option was assessed on a **Does not Meet**, **Partially Meets**, or **Meets** basis (illustrated in **Table 19**). Those options that received **Does not Meet** for any of the Investment Objectives were not taken through to the Stage 1 CSFs assessment. However, the **Do Minimum** was carried through as the base case comparison.

Table 19: Investment Objective Scoring Scale

Does Not Meet (D)	Partially Meets (P)	Meets (M)
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3.4.2 Critical Success Factor Assessment

CSFs outline the elements that are essential for the successful delivery of the HCF investment. CSFs focus on how best to achieve the investment and are an effective way to record the costs and benefits of each option. In comparison, Investment Objectives describe what the investment should achieve to be deemed 'successful'. A formal Cost Benefit Analysis (CBA) was not undertaken due to the complex needs of the HCF population, which make quantifying the benefits provided by a given option difficult (and somewhat unpredictable).

All options that at least **Partially Meet** the Investment Objectives were eligible for assessment against the CSFs to understand how the options support successful delivery of the investment, with scores ranging from **Very Poor** to **Very Good**. Each score has an associated underlying numeric value (as shown in **Table 20**) to enable scores to be tallied and a Preferred Way(s) Forward to be identified. For example, where an option's performance is deemed 'Good,' it receives a score of +1.

Table 20: CSFs Scoring Scale

Very Poor	Poor	Average	Good	Very Good
-2	-1	0	+1	+2

The CSF Assessment was carried out in two phases and **Table 21** provides an overview of the CSFs included in each stage of the assessment. The options that passed the Stage 1 CSF Assessment as well as Option 1: Do Minimum, were programmed and costed. Based on this additional information, the shortlisted options were scored against the Stage 2 CSF criteria to recommend a Preferred Way Forward.

Table 21: CSF Assessment Stage 1 and Stage 2 Criteria

CSF	Description	Weighting
Stage 1		
1.1 Fit-for-purpose	- How well does the option provide for robust, appropriate, and high-quality facilities that offer long term sustainability, safety, and security? - How well does the option provide facilities that meet the therapeutic, cultural, and rehabilitative needs of HCF clients?	25%
1.2 Viability	- How well are MSD, Health New Zealand, and Kāinga Ora placed to deliver these options given the changes required? - How well is the option able to be delivered given the current capability of the disability sector, including providers?	15%
1.3 Workforce Capacity and Capability	How well is the option able to be delivered given the availability and readiness of the workforce?	20%
1.4 Cohort Flexibility	How well does the option enable providers to flexibly manage changes in demand, demographics, and acuity profiles?	25%
1.5 System Flexibility	- How well does the option enable greater flexibility of capacity management across the system? - How well does this option support effective utilisation of the HCF system?	15%
Stage 2		

CSF	Description	Weighting
Stage 1		
2.1 Time	How well does the option support the timely delivery of critical capacity required across the HCF?	40%
2.2 Service Continuity	How well does the option enable MSD to continue providing services across the HCF?	35%
2.3 Affordability	How affordable is the option within the available capital envelope/funding constraints?	25%

To support the assessment rationale, **Table 22** provides an overview of what would constitute a **Very Poor**, **Average**, or **Very Good** score for the Stage 1 and Stage 2 CSFs.

Table 22: CSF Scoring Scale Rationale

CSF	Very Poor -2	Average 0	Very Good +2
1.1 Fit-for-purpose	- More than one facility does not meet the SSM, support cohort management and allow for the provision of robust, safe, and secure care. - Does not meet the care continuum in every region.	- One facility does not meet the SSM, support cohort management and allow for the provision of robust, safe, and secure care. - Partially meets the care continuum or meets the care continuum through centralisation.	- All facilities meet the SSM, support cohort management and allow for the provision of robust, safe, and secure care. - Meets the care continuum in every region.
1.2 Viability	- MSD and their potential delivery partners (i.e. Kāinga Ora and/or Health New Zealand) do not have the organisational maturity, governance structures and experience required to deliver the Option. - MSD and their delivery partners do not have the organisational capacity to deliver the Option and have not made HCF investment an organisational priority. - The Disability Sector (including Providers) does not have the capability, capacity or resources available to deliver the Option.	- MSD and their potential delivery partners have the organisational maturity, governance structures and experience required to deliver the Option. - MSD and their delivery partners have the organisational capacity to deliver the Option, but have not yet made HCF investment an organisational priority. - The Disability Sector (including Providers) has the capability, capacity and resources available to deliver the Option.	- MSD and their potential delivery partners have the organisational maturity, governance structures and experience required to deliver the Option. - MSD and their delivery partners have the organisational capacity to deliver the Option and have made HCF investment an organisational priority. - The Disability Sector (including Providers) has the capability, capacity and resources available to deliver the Option and is preparing for a change of this nature.
1.3 Workforce Capacity and Capability	- Decentralised options do not enable RIDSS workforce efficiencies. - The option retains and refurbishes RIDSAS facilities that do not support staff safety and do not support workforce attraction and retention.	- Centralised RIDSS options enable greater workforce efficiencies for RIDSS. - Mix of refurbished and new build facilities results in some staffing efficiencies through a decrease in relational security needed to manage cohorts.	- Centralised RIDSS and RIDSAS options enable greater workforce efficiencies. - Option builds new facilities that support staff safety, encourage staffing efficiencies through decreased relational security requirements, and support workforce attraction and retention.
1.4 Cohort Flexibility	- Existing layout of retained and refurbished facilities does not support cohort separation. - Few facilities support cohort separation without limiting bed capacity for other HCF clients or impacting relational security.	- Existing layout of retained and refurbished facilities, and provision of some new build facilities, support cohort separation. - Some facilities support cohort separation without limiting bed capacity for other HCF clients or impacting relational security.	All facilities support cohort separation without limiting bed capacity for other HCF clients or impacting relational security.
1.5 System Flexibility	- Does not meet the RIDSS Bed Capacity Plan in all regions. - Decentralised services that do not enable greater system flexibility. - Services are provided from hard to access rural locations.	- Partially meets the RIDSS Bed Capacity Plan. - Centralisation of RIDSS services enables greater system flexibility.	- Meets RIDSS Bed Capacity Plan in all regions. - Centralisation of both RIDSS and RIDSAS services enables greater system flexibility. - Services are provided from urban, easy to access locations.
2.1 Time	Option programming does not prioritise addressing critical capacity and quality concerns before 2035.	Option programming prioritises addressing some critical capacity and quality concerns before 2035.	Option programming prioritises addressing critical capacity and quality concerns before 2035.
2.2 Service Continuity	Option does not have suitable decanting options that will support ongoing delivery of HCF services.	Option has some viable decanting options that will support ongoing delivery of HCF services.	- Option has viable decanting options that will support ongoing delivery of HCF services. - Options that centralise care in the Northern, Central, and Lower Southern regions have opportunities to use existing facilities in the Midlands and Upper Southern for decanting purposes during refurbishment/construction.
2.3 Affordability	Budget significantly exceeds available funding.	Budget somewhat exceeds available funding but can be mitigated through phasing.	Fully affordable within available funding.

3.4.3 Longlist Options Assessment Results

Investment Objectives Assessment

The results of the Investment Objectives Assessment are provided below in **Table 23** with the scoring scale provided in **Table 24**.

Table 23: Investment Objectives Scoring Scale

Does Not Meet (D)	Partially Meets (P)	Meets (M)
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Table 24: Investment Objectives Assessment Results

Option	IO #1: Sufficient flexibility to manage clients and meet demand	IO #2: Facilities are robust, appropriate to the cohort, and homelike	IO #3: Facilities provide a safe, secure environment for staff and clients	IO #4: Facilities protect public safety	Progresses to CSF Assessment?
Option 1: Do Minimum	D	D	D	D	✓ Progresses (as the Do Minimum)
Option 2: Refurbishment and Best Use of Existing Capacity	D	D	D	P	X
Option 3: Meeting Secure Capacity Requirements	D	M	P	P	X
Option 4: Care Continuum through New Build	M	M	M	M	✓
Option 6: Care Continuum with Refurbishment Focus	D	D	D	P	X
Option 7: RIDSS Centralisation	P	M	M	M	✓
Option 8: RIDSS Centralisation – Minimise New Build	P	D	D	P	X
Option 9: RIDSS Centralisation and RIDSAS Hubs	P	M	M	M	✓
Option 10: RIDSS Centralisation and RIDSAS Hubs – Minimise New Build	P	D	D	P	X
Option 11: Do Maximum	M	M	M	M	✓

Based on the Investment Objectives Assessment, Option 4, Option 7, Option 9, and Option 11 were carried forward for assessment against the Stage 1 CSFs. A full breakdown of the assessment rationale is provided

in Appendix I, and the rationale supporting a “Meets” rating for those options carried forward is summarised below:

- Options 4 and 11 “Meet” Investment Objective 1 because they provide additional RIDSS capacity in line with the RIDSS Bed Capacity Plan in every region, thereby providing care continuum, and have a new build focus which provides increased flexibility.
- Options 4 and 7 “Meet” Investment Objective 2 because they either focus on providing new build facilities (Option 4) or a mix of new build and refurbished facilities (Option 7) across all regions to support the provision of appropriate care to clients.
- Options 4, 7, 9 and 11 “Meet” Investment Objective 3 because they focus on new build facilities, with no or few refurbishments, which can be purpose-built to provide a safer and more secure environment for staff and clients.
- Options 4, 7, 9 and 11 “Meet” Investment Objective 4 because they focus on new build facilities, with no or few refurbishments, which can be purpose-built to include better physical security measures.

Option 1 was also carried forward as the Do Minimum option.

CSF Stage 1 Assessment

The CSFs outline the set of criteria that should be fulfilled for successful delivery of the HCF investment. A summary of the CSFs Stage 1 Assessment is provided in **Table 26** below.

Table 25: CSF Scoring Scale

Very Poor	Poor	Average	Good	Very Good
-2	-1	0	+1	+2

Table 26: Stage 1 CSF Assessment Results

Stage 1 CSFs	Option 1: Do Minimum	Option 4: Care Continuum through New Build	Option 7: RIDSS Centralisation	Option 9: RIDSS Centralisation and RIDSAS Hubs	Option 11: Do Maximum
1.1 Fit-for-purpose (25%)	Poor	Very Good	Good	Good	Very Good
1.2 Viability (15%)	Poor	Poor	Poor	Poor	Poor
1.3 Workforce Capacity and Capability (20%)	Poor	Average	Good	Average	Very Poor
1.4 Cohort Flexibility (25%)	Very Poor	Very Good	Good	Good	Very Good
1.5 System Flexibility (15%)	Very Poor	Good	Good	Very Good	Good
Unweighted Score	-7	4	3	3	2
Unweighted Ranking	5	1	2	2	4
Weighted Score	-1.4	1.0	0.70	0.65	0.60
Weighted Ranking	5	1	2	3	4
Result	Progresses to Stage 2 as Do Minimum	Progresses to Stage 2	Progresses to Stage 2	Does not progress to Stage 2	Does not progress to Stage 2

Based on the Stage 1 CSF Assessment, Option 1, Option 4, and Option 7 made the options shortlist and were carried forward for programming, costing, and assessment against the Stage 2 CSFs. Option 4 and Option 7 were carried forward because they received the two highest weighted scores and were the two highest

ranking options in the Stage 1 CSF Assessment, and Option 1 was carried forward for assessment as the Do Minimum.

A full breakdown of the assessment rationale is provided in Appendix J, and the rationale supporting a “Good” or “Very Good” rating for those options carried forward is summarised below:

- Option 4 received a “Very Good” rating for CSF 1 because it focuses on new build facilities, and Option 7 received a “Good” rating because it includes a high proportion of new build facilities.
- Option 7 received a “Good” rating for CSF 3 because of its centralised approach, which allows for greater workforce efficiencies, and focus on new build facilities, which are more likely to support staff safety than refurbished facilities.
- Option 4 received a “Very Good” rating for CSF 4 because it focuses on new build facilities, which can be purpose-built to support cohort flexibility, and refurbishments that will meet the security features of the SSM and support cohort separation. Option 7 received a “Good” rating for CSF 4 for similar reasons but to a lesser extent than Option 4.
- Options 4 and 7 received a “Good” rating for CSF 5 because they both meet the RIDSS Bed Capacity Plan either in every region (Option 4) or every centralised region (Option 7). The centralised approach of Option 7 also allows for greater flexibility and efficiencies compared to the decentralised approach of Option 4.

All options received a “Poor” rating for CSF 2 due to recent changes in the sector and significant funding and workforce challenges, which limit the sector’s capability to deliver on the proposed changes.

3.5 Shortlist Options: Capacity Provided, Benefits, Programming and WOLC

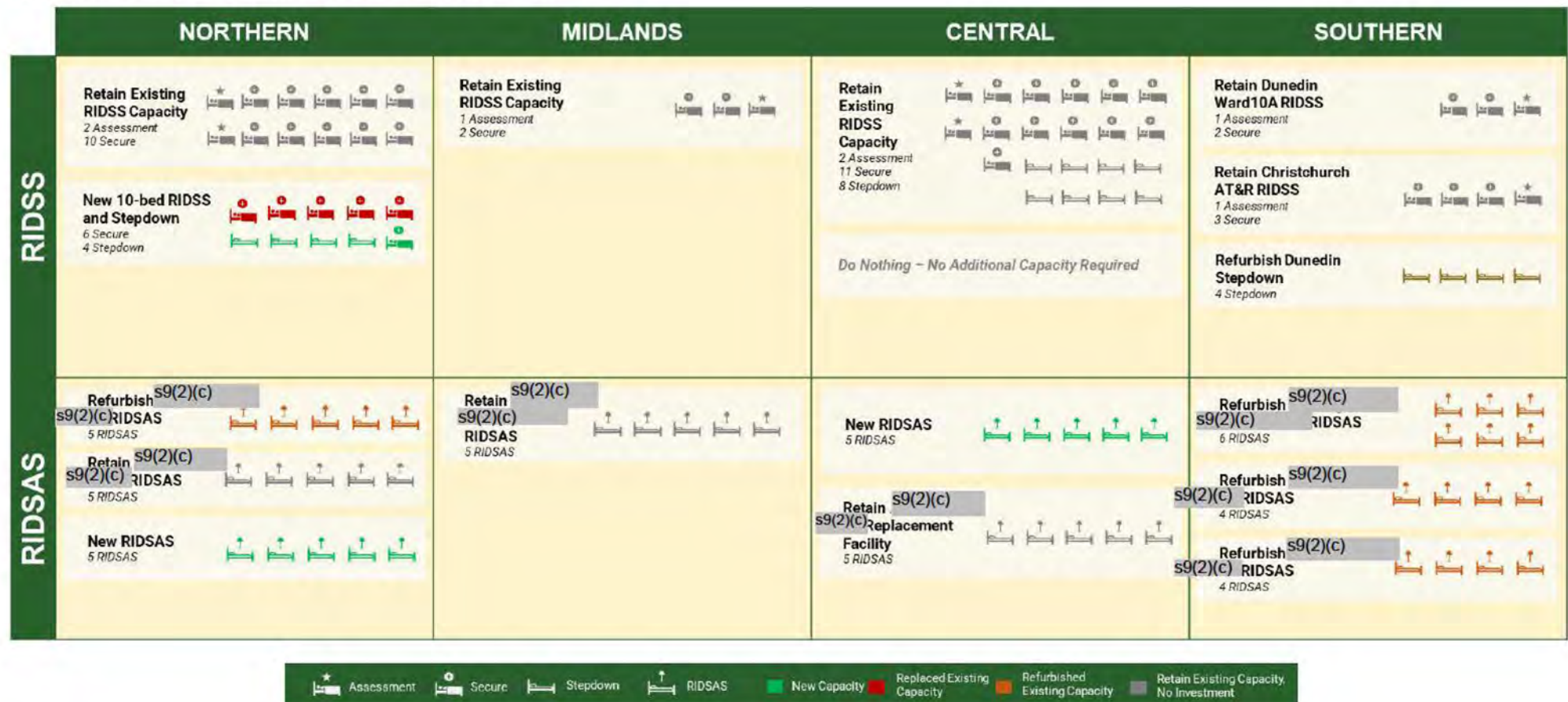
The sections below provide a detailed overview of the Shortlist Options: Option 1, Option 4, and Option 7 to inform the Stage 2 CSF Assessment.

3.5.1 Capacity Provided by the Shortlist Options

Option 1: Do Minimum

The 'Do Minimum' option focuses on providing the minimum level of investment required to address critical concerns across the HCF network. Investment is focused on providing needed secure capacity in key regions and improving existing facility conditions in targeted areas. **Figure 16** provides an overview of the end state beds provided by Option 1.

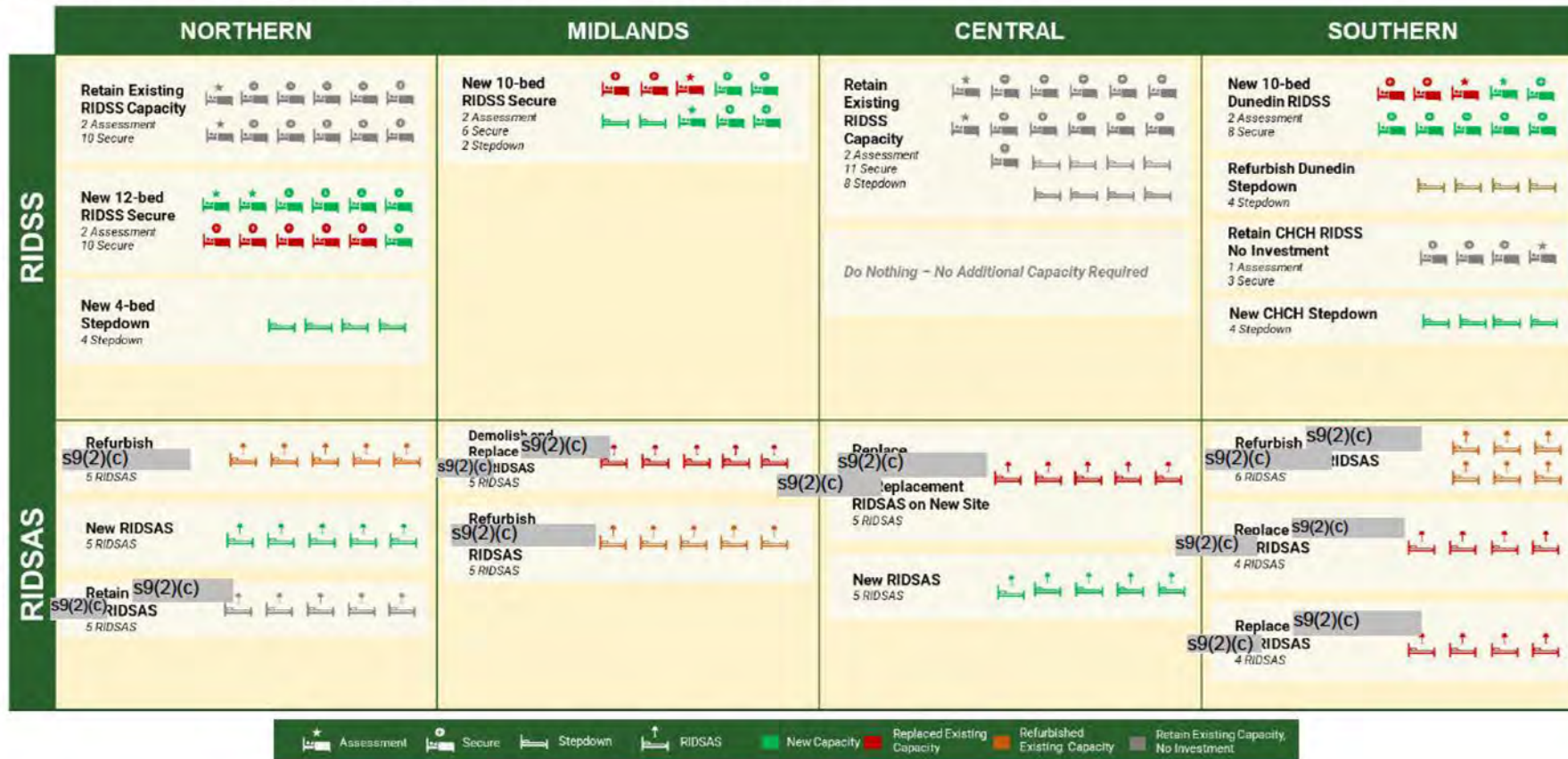
Figure 16: End State Beds provided by Option 1: Do Minimum



Option 4: Care Continuum through New Build

Option 4 received the highest Stage 1 CSF Assessment weighted score. Option 4 focuses on providing the care continuum in each region, predominantly through the provision of new build facilities across all regions where there are existing gaps in the care continuum. **Figure 17** provides an overview of the proposed end state beds provided by Option 4.

Figure 17: End State Beds provided by Option 4: Care Continuum through New Build



A selection of new build RIDSAS facilities in Option 4 can be rebuilt on existing provider owned land (where suitable) or built on new sites, possibly acquired by the Crown. This optionality creates two variations of Option 4, named Option 4a and Option 4b. Table 27 outlines the key differences between Option 4, Option 4a, and Option 4b.

Investment in sites that are not Crown-owned could present a risk to the government. Where providers own highly customised, bespoke facilities, there is a 'lock in' risk for government, where government has few choices but to contract with the provider that owns one of a (very few) facilities that can cater for a unique cohort, almost irrespective of cost or performance. This risk can be appropriately managed and mitigated if the Crown purchase the existing RIDSAS sites that are not Crown-owned. For this reason, the capital cost of each Shortlist Option has been presented in Section 3.5.5 exclusive and inclusive of land acquisition costs to account for the possibility of the government purchasing existing sites and acquiring new RIDSAS sites.

Option 4a assumes the Crown would be able to acquire existing RIDSAS sites that receive capital investment (refurbishment or replacement of existing facility) that are not already Crown owned. If this is not possible, the Crown will need to purchase new sites, and this possibility has been accounted for in Option 4b. The commercial feasibility will be explored in future DBCs.

Table 27: Option 4 Variations 4a and 4b

	Option 4 Care Continuum through New Build	Option 4a Use Existing RIDSAS Sites for New Builds (where possible)	Option 4b Use New RIDSAS Sites for all New Builds
Option Description	Investment focused on providing the care continuum within each region, predominantly through provision of new build facilities across all regions where there are gaps in capacity.	Under Option 4a, existing RIDSAS locations that have been identified as potentially suitable for delivering RIDSAS secure services are retained and the RIDSAS facilities are refurbished or rebuilt to meet the Secure Services Matrix. Where RIDSAS facilities need to be replaced and the locations are deemed unsuitable for RIDSAS secure services (e.g. the facility is near a school), they are rebuilt on new sites.	Under Option 4b, all new build RIDSAS facilities are built on new sites and no new RIDSAS facilities are rebuilt on existing provider owned or leased land.

Refer to Appendix K and Appendix L for figures illustrating facility specific intervention and the number of refurbished and newly built beds provided by Options 4a and 4b. Under both sub-options, there is no difference in RIDSS investment or the number of beds provided. Whether a new facility is built on an existing site or a newly acquired site has no impact on the ability of the option to address critical capacity concerns or meet the care continuum. However, land ownership and location-based factors have implications for the commercial approach required and will be discussed more in the Commercial Case.

Option 7: RIDSS Centralisation

Option 7 received the second highest Stage 1 CSF Assessment weighted score. Option 7 focuses on centralising RIDSS capacity in the North Island and South Island by building new, fit-for-purpose facilities. This supported enhanced efficiency in capacity management and a future-proofed network.

As a centralisation option, Option 7 'centralises' the Midlands RIDSS capacity in the Northern region. This means that the new Northern RIDSS facility delivered by Option 7 both replaces the existing Midlands RIDSS facility capacity and provides additional capacity as required by the Bed Capacity Plan. The existing Midlands RIDSS facility is retained but no longer used to deliver secure HCF services. The same rationale applies to the Southern region, where the existing Upper Southern (Christchurch) RIDSS capacity is transferred to the new Lower Southern (Dunedin) RIDSS facility that also provides additional capacity and supports a centralised service delivery model. The existing Upper Southern facility is retained but no longer used to deliver secure HCF care. Figure 18 provides an overview of the end state beds provided by Option 7.

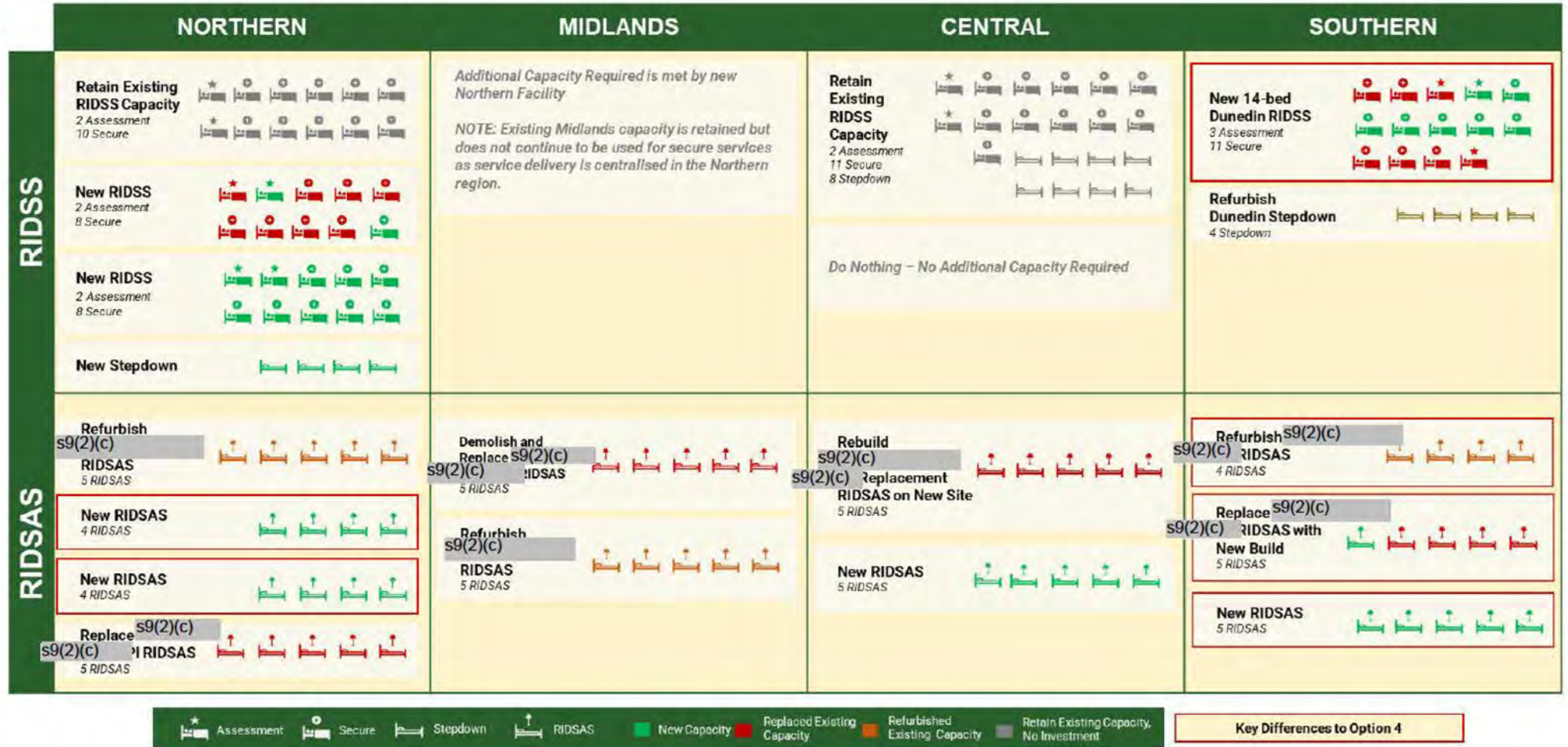
As in Option 4, a selection of new build RIDSAS facilities in Option 7 can be rebuilt on existing provider owned land (where suitable) or built on new sites (possibly acquired by the Crown). This optionality creates two variations of Option 7, named Option 7a and Option 7b. **Table 28** outlines the key differences between Option 7, Option 7a, and Option 7b.

Table 28: Option 7 Variations: 7a and 7b

	Option 7 RIDSS Centralisation	Option 7a Use Existing RIDSAS Sites for New Builds	Option 7b Use New RIDSAS Sites for New Builds
Option Description	Investment is focused on centralising RIDSS capacity in the North Island and South Island through building of new, fit for purpose facilities. This aims to support greater efficiencies in capacity management and a future-proofed network.	Under Option 7a, existing RIDSAS locations that have been identified as potentially suitable for delivering RIDSAS secure services are retained, and the RIDSAS facilities are refurbished or rebuilt to meet the Secure Services Matrix. Where RIDSAS facilities need to be replaced, <i>and</i> the locations are deemed unsuitable for RIDSAS secure services (e.g. the facility is near a school), they are rebuilt on new sites.	Under Option 7b, all new build RIDSAS facilities are built on new sites owned by the government, and no new RIDSAS facilities are rebuilt on existing provider owned or leased land.

Refer to **Appendix M** and **Appendix N** for figures illustrating facility specific intervention and the number of refurbished and newly built beds provided by Options 7a and 7b.

Figure 18: End State Beds provided by Option 7: RIDSS Centralisation



3.5.2 Comparison of Benefits provided by the Shortlist Options

Table 29 provides an overview of the benefits provided by each Shortlist Option.

Table 29: Comparison of Benefits provided by the Shortlist Options

Category	Option 1: Do Minimum	Option 4: Care Continuum through New Build	Option 7: RIDSS Centralisation
Option Description	The 'Do Minimum' option focuses on providing the minimum level of investment required to address critical concerns across the HCF network. Investment is focused on providing needed secure capacity in key regions and improving existing facility conditions in targeted areas.	Investment focused on providing the Care Continuum within each region, predominantly through the provision of new build facilities across all regions where there are gaps.	Investment is focused on centralising RIDSS capacity in the North Island and South Island through building of new, fit for purpose facilities. This aims to enable greater efficiencies in capacity management and a future-proofed network.
Addressing Critical Concerns – Northern Region, RIDSS Capacity	Partially – provides new facilities but does not address capacity requirements.	Yes – through a new 12-bed RIDSS facility.	Yes – through 24 new beds in the Northern region, replacing existing capacity in Northern and Midlands regions.
Addressing Critical Concerns – Midlands Region, RIDSS Capacity	No – no new beds provided.	Yes – through a new 10-bed RIDSS facility.	Partially – provides required RIDSS capacity but in a different region.
Addressing Critical Concerns – Southern Region, Ward 10A	Partially - retains the existing Dunedin Ward 10A RIDSS facility on the assumption that existing planned refurbishments, out of the scope of this PBC will proceed. This is an acceptable interim solution but is not an optimal long-term solution to address quality concerns with Ward 10A.	Yes - through a new 10-bed RIDSS facility which replaces the existing beds and provides additional capacity.	Partially – replaces existing facilities in Dunedin and Christchurch, with a single facility in Dunedin. Provides required capacity but in a single location.
Providing the Care Continuum	- Does not deliver the full Care Continuum in every region. - No Stepdown capacity is provided in the Midlands region, which means HCF clients have to travel outside of the Midlands region to access Stepdown capacity.	Delivers the full Care Continuum in every region.	- Delivers the full Care Continuum in centralised regions only (Northern, Central, Lower Southern). - No RIDSS Assessment, Secure or Stepdown capacity is provided in the Midlands region or Upper Southern (Christchurch) region as capacity is centralised in Northern and Lower Southern (Dunedin) regions.
Meeting the RIDSS Bed Capacity Plan	Does not meet the RIDSS Bed Capacity Plan requirements in every region.	Meets the RIDSS Bed Capacity Plan requirements in every region.	Meets the RIDSS Bed Capacity Plan in centralised regions only. The additional capacity required in the Midlands region is provided in the Northern region.

Category	Option 1: Do Minimum	Option 4: Care Continuum through New Build	Option 7: RIDSS Centralisation
Delivery of Robust, Safe and Secure Facilities	- All existing RIDSAS facilities that receive investment under Option 1 are rebuilt or refurbished to meet the SSM. - Retains the s9(2)(c) Replacement RIDSAS facilities for secure use with no investment. These facilities do not meet the SSM.	All existing RIDSAS facilities that receive investment under Option 4 are rebuilt or refurbished to meet the SSM.	All existing RIDSAS facilities that receive investment under Option 1 are rebuilt or refurbished to meet the SSM.

3.5.3 Comparison of Investment under the Shortlist Options

Table 30 provides a comparison of facility interventions under the Shortlist Options. Green boxes highlight key differences between the options, and the number of end state beds is provided in *italics*.

Table 30: Comparison of Facility Intervention under the Shortlist Options

		Option 1	Option 4a	Option 4b	Option 7a	Option 7b
Northern	RIDSS	Retain Existing RIDSS Capacity <i>2 Assessment, 10 Secure</i>	Retain Existing RIDSS Capacity <i>2 Assessment, 10 Secure</i>	Retain Existing RIDSS Capacity <i>2 Assessment, 10 Secure</i>	Retain existing RIDSS Capacity <i>2 Assessment, 10 Secure</i>	Retain existing RIDSS Capacity <i>2 Assessment, 10 Secure</i>
		New 10-bed RIDSS and Stepdown Facility <i>6 Secure, 4 Stepdown</i>	New 12-bed RIDSS <i>2 Assessment, 10 Secure</i>	New 12-bed RIDSS <i>2 Assessment, 10 Secure</i>	New 10-bed RIDSS Secure Facility <i>2 Assessment, 8 Secure</i>	New 10-bed RIDSS Secure Facility <i>2 Assessment, 8 Secure</i>
			New 4-bed Stepdown <i>4 Stepdown</i>	New 4-bed Stepdown <i>4 Stepdown</i>	New 10-bed RIDSS Secure Facility <i>2 Assessment, 8 Secure</i>	New 10-bed RIDSS Secure Facility <i>2 Assessment, 8 Secure</i>
	RIDSAS	Refurbish s9(2)(c) 5-bed RIDSAS to meet SSM <i>5 RIDSAS</i>	Refurbish s9(2)(c) 5-bed RIDSAS to meet SSM <i>5 RIDSAS</i>	Refurbish s9(2)(c) 5-bed RIDSAS to meet SSM <i>5 RIDSAS</i>	Refurbish s9(2)(c) 5-bed RIDSAS to meet SSM <i>5 RIDSAS</i>	Refurbish s9(2)(c) 5-bed RIDSAS to meet SSM <i>5 RIDSAS</i>
		New 5-bed RIDSAS on new site <i>5 RIDSAS</i>	New 5-bed RIDSAS on new site <i>5 RIDSAS</i>	New 5-bed RIDSAS on new site <i>5 RIDSAS</i>	New 4-bed RIDSAS on new site <i>4 RIDSAS</i>	New 4-bed RIDSAS on new site <i>4 RIDSAS</i>
		Retain s9(2)(c) No Investment <i>5 RIDSAS</i>	Retain s9(2)(c) , No Investment <i>5 RIDSAS</i>	Retain s9(2)(c) , No Investment <i>5 RIDSAS</i>	Replace s9(2)(c) with New Build on Existing Site <i>5 RIDSAS</i>	Replace s9(2)(c) with New Build on New Site <i>5 RIDSAS</i>
Midlands	RIDSS	Retain Existing RIDSS Capacity <i>1 Assessment 2 Secure</i>	New 10-bed RIDSS Secure Facility (Replace Existing Capacity) <i>2 Assessment, 6 Secure, 2 Stepdown</i>	New 10-bed RIDSS Secure Facility (Replace Existing Capacity) <i>2 Assessment, 6 Secure, 2 Stepdown</i>		
	RIDSAS	Retain s9(2)(c) for Secure Use with No Investment <i>5 RIDSAS</i>	Refurbish s9(2)(c) RIDSAS to Meet SSM <i>5 RIDSAS</i>	Refurbish s9(2)(c) RIDSAS to Meet SSM <i>5 RIDSAS</i>	Refurbish s9(2)(c) RIDSAS to Meet SSM <i>5 RIDSAS</i>	Refurbish s9(2)(c) RIDSAS to Meet SSM <i>5 RIDSAS</i>

		Option 1	Option 4a	Option 4b	Option 7a	Option 7b
		No longer use s9(2)(c) for secure capacity	Demolish and Replace s9(2)(c) RIDSAS on Existing Site 5 RIDSAS	Demolish and Replace s9(2)(c) RIDSAS on New Site 5 RIDSAS	Demolish and Replace s9(2)(c) RIDSAS on Existing Site 5 RIDSAS	Demolish and Replace s9(2)(c) RIDSAS on New Site 5 RIDSAS
Central	RIDSS	Retain Existing RIDSS Capacity 2 Assessment, 11 Secure, 8 Stepdown No additional capacity required	Retain Existing RIDSS Capacity 2 Assessment, 11 Secure, 8 Stepdown No additional capacity required	Retain Existing RIDSS Capacity 2 Assessment, 11 Secure, 8 Stepdown No additional capacity required	Retain Existing RIDSS Capacity 2 Assessment, 11 Secure, 8 Stepdown No additional capacity required	Retain Existing RIDSS Capacity 2 Assessment, 11 Secure, 8 Stepdown No additional capacity required
	RIDSAS	New RIDSAS 5 RIDSAS Retain s9(2)(c) Replacement RIDSAS Facility 5 RIDSAS	New RIDSAS 5 RIDSAS Replace s9(2)(c) Replacement Facility 5 RIDSAS	New RIDSAS 5 RIDSAS Replace s9(2)(c) Replacement Facility 5 RIDSAS	New RIDSAS 5 RIDSAS Replace s9(2)(c) Replacement Facility 5 RIDSAS	New RIDSAS 5 RIDSAS Replace s9(2)(c) Replacement Facility 5 RIDSAS
Upper Southern (CHCH)	RIDSS	Retain 4-bed AT&R, No Investment 1 Assessment, 3 Secure	Retain 4-bed AT&R, No Investment 1 Assessment, 3 Secure New CHCH Stepdown 4 Stepdown	Retain 4-bed AT&R, No Investment 1 Assessment, 3 Secure New CHCH Stepdown 4 Stepdown		
	RIDSAS	Refurbish s9(2)(c) to meet SSM 4 RIDSAS Refurbish s9(2)(c) to meet SSM 6 RIDSAS	Replace s9(2)(c) with New Facility on Existing Site 4 RIDSAS Refurbish s9(2)(c) to meet SSM 6 RIDSAS	Replace s9(2)(c) with New Facility on New Site 4 RIDSAS Refurbish s9(2)(c) to meet SSM 6 RIDSAS	Refurbish s9(2)(c) to meet SSM 4 RIDSAS	Refurbish s9(2)(c) to meet SSM 4 RIDSAS
Lower Southern (DUN)	RIDSS	Retain Ward 10A 1 Assessment, 2 Secure Refurbish Existing 4-bed Stepdown Cottage 4 Stepdown	Replace Ward 10A with new 10-bed facility 2 Assessment, 8 Secure Refurbish Existing 4-bed Stepdown Cottage 4 Stepdown	Replace Ward 10A with new 10-bed Facility 2 Assessment, 8 Secure Refurbish Existing 4-bed Stepdown Cottage 4 Stepdown	Replace Ward 10A and CHCH AT&R with new 14-bed Facility 3 Assessment, 11 Secure Refurbish Existing 4-bed Stepdown Cottage 4 Stepdown	Replace Ward 10A and CHCH AT&R with new 14-bed Facility 3 Assessment, 11 Secure Refurbish Existing 4-bed Stepdown Cottage 4 Stepdown
	RIDSAS	Refurbish s9(2)(c) to meet SSM 4 RIDSAS	Replace s9(2)(c) with New Build on Existing Site 4 RIDSAS	Replace s9(2)(c) with New Build on New Site 4 RIDSAS	Replace s9(2)(c) with New Build on Existing Site 5 RIDSAS New Build RIDSAS 4 RIDSAS	Replace s9(2)(c) with New Build on New Site 5 RIDSAS New Build RIDSAS 4 RIDSAS

3.5.4 Shortlist Options – Programming

A series of workshops was held in August 2024 with representatives from Klein (specialist architects and designers for healthcare facilities), Rider Levitt Bucknall (quantity surveyors) and Whaikaha to understand the programming requirements for the shortlist options. For this PBC stage, a set of simplifying assumptions was used to develop the programmes:

- Delivering RIDSAS investments before RIDSS investments will improve efficiency of existing RIDSS
- Design efficiencies may be gained following completion of initial refurbishment/new build design
- Design periods do not allow for lengthy approvals processes
- Minimum design standards are developed prior to design period
- Decanting detail will be included in later business cases and will not delay the design and build timeframes
- No facility demolition required unless specifically mentioned
- Facilities that are retained but no longer used for secure services are used for other purposes (agency/NGO decision)
- Land is already acquired, ready for design and build phases to commence.

Based on these assumptions, the following three approaches for options programming were developed:

- **Approach One:** Regional investment is prioritised by population demand and existing facility condition to ensure critical concerns are addressed first. For example, there is a critical need to increase the number of Secure and Stepdown beds in the Northern region. Based on this need, the Northern region is always the priority for investment under this approach. Refer to **Figure 19**, **Figure 20**, and **Figure 21** below for more information and an overview of programming for Option 1, Option 4, and Option 7.
- **Approach Two:** All RIDSS facility investment occurs before RIDSAS investment. This approach delivers RIDSS investment prior to RIDSAS investment. Refer to Appendix O for more details.
- **Approach Three:** Virtually all RIDSAS facility investment occurs before RIDSS investment. This approach recognises that because all RIDSS investment occurs on hospital sites, it is likely that the design and build process for RIDSAS will be more efficient than RIDSS investment. It is also assumed that delivering RIDSAS investment before RIDSS investments will improve the efficiency of existing RIDSS facilities. Refer to **Appendix P** for more details.

In discussions with Whaikaha about the feasibility of each approach, it became apparent that the only credible approach is **Approach One: Prioritise by Population Demand (Hybrid)** (referred to as “Programming Approach One: Hybrid”). Approaches that rigidly prioritise investment in one facility type or another do not support the realities of demand and system management for this population. The preferred approach takes a system approach and balances the need to address critical quality and capacity issues with overall demand and clinical flows. The hybrid approach also allows for the most efficient use of the system – balancing the delivery of new capacity in RIDSS with the supply of enough step-down care to allow for smooth functioning of the network.

A summary of when new RIDSS capacity is delivered in each Shortlist Option to meet the RIDSS Bed Capacity Plan additional capacity requirements according to Programming Approach One: Hybrid is provided in **Table 31** below. Please note that the new capacity provided (i.e. to support the care continuum) but that is not required by the RIDSS Bed Capacity Plan, is not shown in the figure below.

Table 31: Delivery of Additional RIDSS Capacity per the RIDSS Bed Capacity Plan

Option 1 – Do Minimum, Delivery of New RIDSS Capacity													
Region	RIDSS Bed Capacity Plan – Additional Beds Required	Year Capacity Delivered by Option – Completion of Construction										TOTAL	RIDSS Bed Capacity Required Met Before FY35?
		FY 29	FY 30	FY 31	FY 32	FY 33	FY 34	FY 35	FY 36	Post FY 36			
Northern	+2 Assessment	n/a – requirement not met by Option 1										Not Met	
	+5 Secure			+1							+1	Not Met	
	+4 Stepdown			+4							+4	✓	
Midlands	+1 Assessment	n/a – requirement not met by Option 1										Not Met	
	+4 Secure	n/a – requirement not met by Option 1										Not Met	
	+0 Stepdown	n/a – no additional capacity required by the Bed Capacity Plan										n/a	
Central	+0 Assessment	n/a – no additional capacity required by the Bed Capacity Plan										n/a	
	+0 Secure	n/a – no additional capacity required by the Bed Capacity Plan										n/a	
	+0 Stepdown	n/a – no additional capacity required by the Bed Capacity Plan										n/a	
Southern	+1 Assessment	n/a – requirement not met by Option 1										Not Met	
	+6 Secure	n/a – requirement not met by Option 1										Not Met	
	+0 Stepdown	n/a – not required by the RIDSS Bed Capacity Plan										n/a	
Option 4 – Care Continuum through New Build, Delivery of New RIDSS Capacity													
Region	RIDSS Bed Capacity Plan – Additional Beds Required	Year Capacity Delivered by Option – Completion of Construction										TOTAL	RIDSS Bed Capacity Required Met Before FY35?
		FY29	FY30	FY31	FY32	FY33	FY34	FY35	FY36	Post FY36			
Northern	+2 Assessment			+2							+2	✓	
	+5 Secure			+5							+5	✓	
	+4 Stepdown			+4							+4	✓	
Midlands	+1 Assessment									+1	+1	Post FY35	
	+4 Secure									+4	+4	Post FY35	
	+0 Stepdown	n/a – no additional capacity required by the Bed Capacity Plan										n/a	
Central	+0 Assessment	n/a – no additional capacity required by the Bed Capacity Plan										n/a	
	+0 Secure	n/a – no additional capacity required by the Bed Capacity Plan										n/a	
	+0 Stepdown	n/a – no additional capacity required by the Bed Capacity Plan										n/a	
Southern	+1 Assessment									+1	+1	Post FY35	
	+6 Secure									+6	+6	Post FY35	
	+0 Stepdown	n/a – no additional capacity required by the Bed Capacity Plan										n/a	

Option 7 – RIDSS Centralisation, Delivery of New RIDSS Capacity												
Region	RIDSS Bed Capacity Plan – Additional Beds Required	Year Capacity Delivered by Option – Completion of Construction										RIDSS Bed Capacity Required Met Before FY35?
		FY29	FY30	FY31	FY32	FY33	FY34	FY35	FY36	Post FY 35	TOTAL	
Northern	+2 Assessment				+3						+3	✓
	+5 Secure				+9						+9	✓
	+4 Stepdown				+4						+4	✓
Midlands	+1 Assessment	n/a – additional capacity met through new Northern facilities										n/a
	+4 Secure	n/a – additional capacity met through new Northern facilities										n/a
	+0 Stepdown	n/a – no additional capacity required by the Bed Capacity Plan										n/a
Central	+0 Assessment	n/a – no additional capacity required by the Bed Capacity Plan										n/a
	+0 Secure	n/a – no additional capacity required by the Bed Capacity Plan										n/a
	+0 Stepdown	n/a – no additional capacity required by the Bed Capacity Plan										n/a
Southern	+1 Assessment									+1	+1	Post FY35
	+6 Secure									+6	+6	Post FY35
	+0 Stepdown	n/a – no additional capacity required by the Bed Capacity Plan										n/a

A summary of when new refurbished RIDSAS capacity is delivered by each Shortlist Option according to Programming Approach One: Hybrid is provided in **Table 32** below. Note that the table excludes facilities that are retained for secure use with no investment.

Table 32: Delivery of New Build and Refurbished RIDSAS Capacity

Option 1 – Do Minimum											
Region	Year RIDSAS Capacity (# Beds) Delivered by Option – Completion of New Build Construction/Refurbishment										
	FY28	FY29	FY30	FY31	FY32	FY33	FY34	FY35	FY36	Post FY36	TOTAL
Northern		5								5	10
Midlands											0
Central			5								5
Southern				4	6					4	14
Option 4 – Care Continuum through New Build											
Region	Year RIDSAS Capacity (# Beds) Delivered by Option – Completion of New Build Construction/Refurbishment										
	FY28	FY29	FY30	FY31	FY32	FY33	FY34	FY35	FY36	Post FY36	TOTAL
Northern		10									10
Midlands						10					10
Central			10								10
Southern							4	4	6		14
Option 7 – RIDSS Centralisation											
Region	Year RIDSAS Capacity (# Beds) Delivered by Option – Completion of New Build Construction/Refurbishment										
	FY28	FY29	FY30	FY31	FY32	FY33	FY34	FY35	FY36	Post FY36	TOTAL

	FY28	FY29	FY30	FY31	FY32	FY33	FY34	FY35	FY36	Post FY36	TOTAL
Northern		18									18
Midlands										10	10
Central			10								10
Southern					14						14

The figures below provide an overview of the full Shortlist Options programming according to Programming Approach One: Hybrid. In the figures below, **blue** represents the estimated design period, with **pink** representing the estimated construction period.

Within the Option 4 and Option 7 programmes, five tranches have been identified to separate RIDSS and RIDSAS investment. This separation reflects the likelihood that the RIDSS and RIDSAS investments are delivered by different agencies and retains programme delivery flexibility. Within the Option 1 programme, four tranches have been identified that also separate RIDSS and RIDSAS investment.

Figure 19: Option 1 Programming, Prioritise by Population Demand (Hybrid)

s9(2)(i)



Figure 20: Option 4 Programming, Prioritise by Population Demand (Hybrid)

s9(2)(i)



Figure 21: Option 7 Programming, Prioritise by Population Demand (Hybrid)

s9(2)(j)



Key	
Design period	
Construction period	

Quarters	
1	July - September
2	October - December
3	January - March
4	April - June

3.5.5 Shortlist Options – Capital Costs

Capital Costs - Facility Design and Construction

A summary of the estimated hybrid priority capital costs (real, nominal, and present value) for each Shortlist Option is provided in **Table 33** and **Table 34** below. The capital costs include the design and construction/refurbishment of RIDSS and RIDSAS facilities and exclude the cost of demolition and of acquiring RIDSAS land. The Present Value (PV) was calculated applying a real discount rate of 2.0% (FY25).¹⁹ Refer to **Appendix Q** for the Quantity Surveyor (RLB) estimates and assumptions to date and **Appendix R** for the Klein Design Report.

Table 33: Capital Costs (Nominal) - Hybrid Priority (excluding land acquisition)

Table 34: Capital Costs (Real) – Hybrid Priority (excluding land acquisition)

Overall, Option 1 has the lowest capital cost of all the Shortlist Options and Option 7 has the highest capital cost across the real, nominal and PV analysis.

¹⁹ The Treasury, Discount Rates, accessed 3 December 2024 via <https://www.treasury.govt.nz/information-and-services/state-sector-leadership/guidance/reporting-financial/discount-rates>

Land Acquisition Costs

The capital costs provided in Table 31 outline the cost of RIDSS and RIDSAS facility design and construction, and exclude the cost of RIDSAS land acquisition. While new RIDSS facilities will be built on existing Crown owned land, the construction of new RIDSAS facilities may require the acquisition of new land. Depending on the Preferred Option and commercial approach selected, the Crown may decide to purchase existing RIDSAS sites from either the provider (if the RIDSAS facility is provider owned) or landowner (if the RIDSAS provider leases/rents the facility from a third-party) where the facilities are due for refurbishment or replacement and are not already Crown owned.

It would cost an estimated \$9.59m to purchase the existing RIDSAS facilities that are not currently owned by the Crown based on the most recent capital value available. In addition, purchasing sites for new RIDSAS facilities is estimated to cost between \$600k and \$1.5m per property (depending on region) based on land value in existing RIDSAS locations, required RIDSAS site sizes and minimum council lot sizes (depending on the relevant local authority). **Appendix V** outlines the estimated cost to purchase existing RIDSAS facilities that are not currently owned by the Crown based on the most recent capital value available. For existing RIDSAS sites, the capital cost to purchase the site includes both land and improvement value.

Refer to **Appendix V** for the full list of assumptions used to estimate the existing RIDSAS and RIDSAS land acquisition costs for each region.

This Economic Case assumes that only those RIDSAS facilities and sites that receive investment through the programme will be purchased by the Crown. It is assumed that those RIDSAS facilities and sites that are retained for secure use with no investment are not purchased by the Crown.

Refer to **Appendix R** for the real and nominal land acquisition costs by option.

Capital Costs, including Land Acquisition

A summary of the estimated hybrid priority capital costs (real, nominal and present value) for each Shortlist Option is outlined in **Table 35** and **Table 36** below and includes the cost of acquiring RIDSAS land. The PV was calculated applying a real discount rate of 2.0% (FY25).²⁰ Refer to **Appendix T** for the capital costs by facility (including land acquisition costs).

Table 35: Capital Costs (Nominal) - Hybrid Priority (including land acquisition costs)

s9(2)(i)

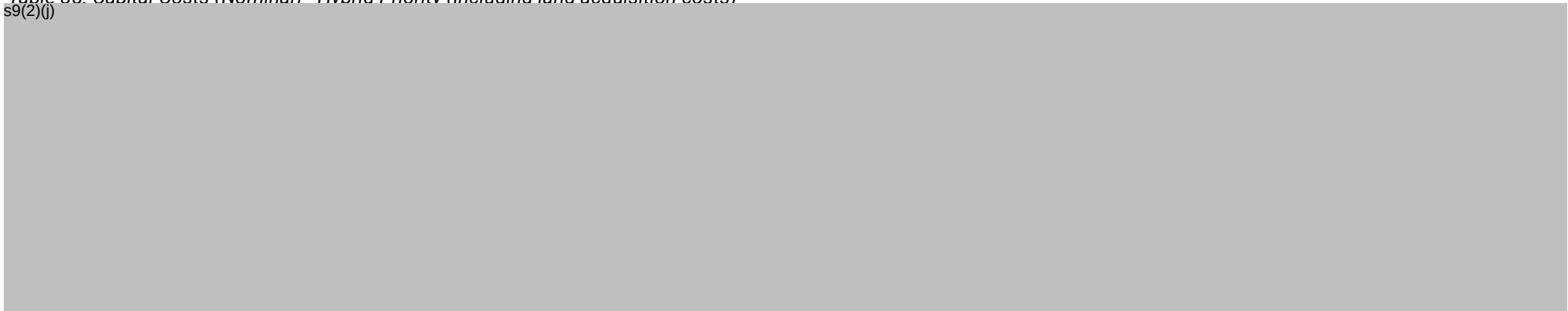
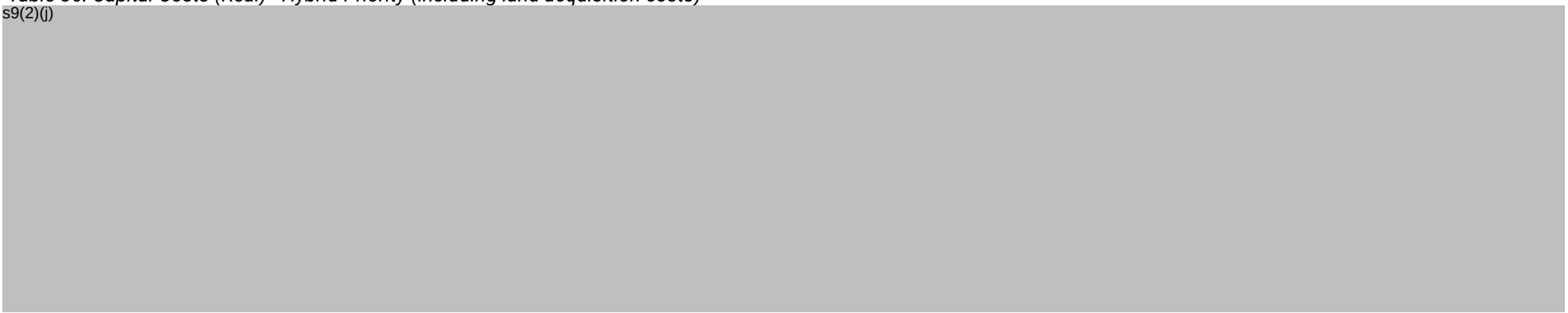
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Table 36: Capital Costs (Real) - Hybrid Priority (including land acquisition costs)

s9(2)(i)

A large rectangular area of the page is redacted with a solid grey fill, covering the content of Table 36.

²⁰ The Treasury, Discount Rates, accessed 3 December 2024 via <https://www.treasury.govt.nz/information-and-services/state-sector-leadership/guidance/reporting-financial/discount-rates>

3.5.6 Shortlist Options – Whole of Life Cost

The Whole of Life Costs (WOLC) for the Shortlist Options: Option 1, Option 4 and Option 7 are summarised in **Table 37** below.

Table 37: WOLC Summary (real)
s9(2)(j)

3.6 Shortlist Options Assessment

Based on the Shortlist Option programming and WOLC information, the Stage 2 CSF Assessment was conducted based on three additional CSFs: Time, Sector Viability and Affordability. This assessment is informed by information on the Shortlist Options programming, capital costs and WOLC. Only the Shortlist Options that passed the Stage 1 CSF Assessment were programmed and costed.

A summary of the CSF Stage 2 Assessment is provided in **Table 38** below. The full CSF Stage 2 assessment rationale is provided in Appendix U.

Table 38: Summary of CSF Stage 2 Assessment

Stage 2 CSF Assessment	Option 1: Do Minimum	Option 4: Care Continuum through New Build	Option 7: RIDSS Centralisation
CSF 2.1 Time (40%)	Good	Good	Very Good
CSF 2.2 Service Continuity (35%)	Very Poor	Good	Good
CSF 2.3 Affordability (25%)	Good	Average	Poor
Unweighted Score	0	2	1
Unweighted Ranking	3	1	2
Weighted Score	-0.05	0.75	0.65
Weighted Ranking	3	1	2

The CSF assessment makes a compelling case for investment in Option 4 as the Preferred Way Forward. When compared with other longlist options, it best meets the needs of staff, clients, and system capacity requirements. Option 4 includes new build investments that enable greater efficiencies in capacity management and a future-proofed network that can continue to provide sustained, fit-for-purpose, therapeutic care over a long-term period. The emphasis on new build also offers greater cost efficiencies by minimising ongoing facilities maintenance and repair costs, by delivering robust, safe and secure facilities at the outset. Further detailed discussion on the benefits of the Preferred Way Forward is set out in the following section.

3.7 Preferred Way Forward

Based on the analysis conducted in this Economic Case, Option 4 has been recommended as the Preferred Way Forward as the highest scoring option.

Option 4 provides flexible, robust, safe, and secure RIDSS and RIDSAS facilities that provide a homelike environment for HCF clients whilst protecting client, staff and public safety and balancing value for money through a mix of refurbished and new build facilities.

One of the main differences between the shortlisted Option 4 and Option 7 is the choice of service delivery model, with Option 4 focused on decentralised service delivery and Option 7 focused on centralised service delivery. While both models have advantages and disadvantages, a decentralised service delivery method is preferred by DSS as it (i) achieves desired placement outcomes, (ii) ensures clients are close to whānau, and (iii) provides the care continuum in all regions.

A further benefit of Option 4 is its relatively lower capital and whole of life costs. Under the preferred hybrid programming approach, Option 7 delivers a larger number of RIDSS/RIDSAS facilities earlier than Option 4, which makes Option 7 more expensive than Option 4 on a discounted basis. For example, Option 4a (use existing RIDSAS sites) has a discounted capital cost of \$114.33m compared to Option 7a (use existing RIDSAS sites), which has a higher discounted capital cost of \$131.02m. Both Option 4a and 4b have a lower whole of life cost (\$451.07m and \$450.95m, respectively) compared to Options 7a and 7b (\$534.01m and \$532.10m). This is reflective of Option 4's lower incremental capital cost, operating cost, depreciation, and capital charge on a real basis (compared to Option 7).

Option 4 addresses the network's critical capacity and quality issues across all regions through refurbished or new-build facilities replacing existing beds and providing additional capacity in line with the RIDSS Bed Capacity Plan. It provides the care continuum in all regions, not just centralised regions (as in Option 7), and aligns with the decentralised method of care delivery, which better meets the needs of clients and their families.

4. Commercial Case

This Commercial Case describes the approach to be taken for the procurement and delivery of the Preferred Option (Option 4) outlined in the Economic Case.

The Commercial Case describes the:

- Programme characteristics: outlining the programme scope of services, scale, and risks
- Procurement strategy: outlining the procurement criteria, packaging options, ownership scenarios and responsible parties
- Contract provisions: outlining the forms of contract, contract length, proposed contract clauses, potential of risk sharing, payment mechanisms and accountancy treatment.

Given the nature of a PBC and the number of agencies involved in delivering services for clients of the HCF, this Commercial Case considers delivery arrangements at a high level and will need to be confirmed through subsequent business cases. For this Commercial Case:

- **Focus is primarily on Tranche One:** to retain flexibility and respond to changes given the early stage of the programme and ongoing conversations with stakeholders and delivery partners. It is expected that all tranches will use a similar commercial and procurement approach.
- **Focus is primarily on RIDSAS:** given that Tranche One focuses on RIDSAS, and given that further decisions are required on the best approach for RIDSS.
- **Presenting potential facility ownership and procurement management scenarios:** at the time of writing the PBC, neither the final ownership of the RIDSAS facilities nor the agency that will manage the capital delivery activities is finalised, and this will be resolved through subsequent business cases. As such, RIDSAS facility ownership options are discussed, and procurement management scenarios are presented with advantages and disadvantages.

In October 2024, MSD signed a services agreement with Crown Infrastructure Delivery Limited (CID). This Commercial Case assumes that CID will be delegated the authority to act as principal to the contracts for Tranche One RIDSAS facilities. CID has extensive commercial and procurement capability and will carry out procurement in line with its best practice.

4.1 Programme Characteristics

The programme involves the provision of services to design, build, manage and operate RIDSAS and RIDSS facilities as outlined in the Economic Case for the Preferred Option, Option 4. The initial focus of this programme is on Tranche One, relating to RIDSAS facilities in the Northern and Central regions.

As outlined in the Strategic Case, RIDSAS services relate to community level support and supervised care for HCF intellectually disabled individuals in specialised residential facilities. Often these facilities have higher levels of security and safety provisions in place to keep residents, staff and the public safe. Historically, RIDSAS facilities have been owned and operated by contracted private and non-government providers, with some facilities owned by Kāinga Ora and leased to providers. The intent is for future RIDSAS facilities to be Crown-owned, although provision of operational care and facility management services will continue to be delivered by private and non-government providers.

RIDSS services relate to secure hospital level care for HCF intellectually disabled individuals, and the facilities and services are normally delivered by Health New Zealand. No RIDSS facilities receive investment under Tranche One, and therefore, RIDSS services are not covered in detail in this Commercial Case.

Key programme characteristics, including high level scope, are outlined in **Figure 22**.

Figure 22: Programme Characteristics

Characteristics	Description
Scope of Services	Tranche One of the Preferred Option includes the construction of three new build RIDSAS facilities across Northern and Central Regions and the refurbishment of one existing facility in the Northern Region. The existing Northern facility s9(2)(c) will require refurbishment works to meet the SSM, with key areas including the windows, fencing, and alarm system. The three new build RIDSAS facilities will require full construction works and fit out, as sites for these facilities are yet to be identified, the extent of preparatory works is currently unknown. It has been assumed that some level of site-enablement works (including demolition) may be required to appropriately prepare the sites. Broadly, the scope of services is expected to include: Design Services • Facility architecture and design • Design project management • Legal / Surveying (land acquisition and consenting support) • Quantity Surveying Build Services • Build project management • Ground remediation and site preparation (enabling works) • Demolition of existing structures • Refurbishment of the existing facility – inclusive of minor capital works (i.e. fencing and windows) and general refurbishment activities (e.g. paintings, fixtures) • Construction • Associated civil works, external hardscaping, fencing, and landscaping • Fixtures, Furnishings, and Equipment supply and installation Soft Facilities Management (FM) Services • Cleaning • Waste management • Landscaping • Pest control Hard FM Services • Facility inspections • Facility maintenance • Fixtures, furnishing and equipment maintenance • Electrical services • Plumbing services • Heating, ventilation and air conditioning • Fire safety systems • Security and other technology systems Service Provision • Facility management • Resident care and support services • Resident assistance with food preparation, laundry and cleaning • Resident safety and security

Characteristics	Description									
Scale and Investment	Tranche One work includes: ▪ Refurbishment of 1 Northern Region 5-bed facility s9(2)(c) to meet SSM: the facility will remain a 5-bed facility after refurbishment, and will continue to require the provision of hard FM, soft FM and resident support services ▪ Design and build of 1 new Northern Region 5-bed facility, and subsequently the provision of hard FM, soft FM and resident support services ▪ Design and build of 2 new Central Region 5-bed facility, and subsequently the provision of hard FM, soft FM and resident support services. Tranche One refurbishment and construction capital cost for four RIDSAS facilities in Tranche One is expected to be approximately \$30.9 million (nominal). HCF services have existing operating costs today. These operating costs are not expected to be impacted by the changes proposed in this PBC until the Tranche One RIDSAS facilities go into operation in FY30. In FY30, the Tranche One operating cost is expected to be \$3.09 million (nominal), rising to between \$6 and \$8 million per annum for the remaining years of the 2030 decade.									
Risks	Programme risks identified for the refurbishment and construction of the four Tranche One RIDSAS facilities are set out in this table: <table><tr><th>Risk</th><th>Description</th><th>Mitigation</th></tr><tr><td>Meeting design and build specifications</td><td>RIDSAS facilities need to meet specific security, safety, support and capacity needs suitable for the HCF residents, staff and public.</td><td> • Tight design and build contractual agreements that commit suppliers to meeting SSM and other needs • Use of contractual providers with experience delivering facilities to meet similar needs. • CID appointed to act for MSD and as Principal to contracts with suppliers. Utilise experience managing design and build contractual processes to ensure specifications are achieved. </td></tr><tr><td>Provider misalignment</td><td>There is a risk that the different providers for design, build, soft FM, hard FM, and service provision do not align to provide a cohesive end-to-end solution that meets HCF needs.</td><td> • Agree on contracts that incentivise provider alignment • Undertake careful contractual management and oversight to clearly define and manage accountability. • CID appointed to oversee the infrastructure delivery process and consider using the experience to manage the assets post construction so that MSD can hold a single entity to account for delivering an end-to-end solution that meets HCF needs. </td></tr></table>	Risk	Description	Mitigation	Meeting design and build specifications	RIDSAS facilities need to meet specific security, safety, support and capacity needs suitable for the HCF residents, staff and public.	• Tight design and build contractual agreements that commit suppliers to meeting SSM and other needs • Use of contractual providers with experience delivering facilities to meet similar needs. • CID appointed to act for MSD and as Principal to contracts with suppliers. Utilise experience managing design and build contractual processes to ensure specifications are achieved.	Provider misalignment	There is a risk that the different providers for design, build, soft FM, hard FM, and service provision do not align to provide a cohesive end-to-end solution that meets HCF needs.	• Agree on contracts that incentivise provider alignment • Undertake careful contractual management and oversight to clearly define and manage accountability. • CID appointed to oversee the infrastructure delivery process and consider using the experience to manage the assets post construction so that MSD can hold a single entity to account for delivering an end-to-end solution that meets HCF needs.
Risk	Description	Mitigation								
Meeting design and build specifications	RIDSAS facilities need to meet specific security, safety, support and capacity needs suitable for the HCF residents, staff and public.	• Tight design and build contractual agreements that commit suppliers to meeting SSM and other needs • Use of contractual providers with experience delivering facilities to meet similar needs. • CID appointed to act for MSD and as Principal to contracts with suppliers. Utilise experience managing design and build contractual processes to ensure specifications are achieved.								
Provider misalignment	There is a risk that the different providers for design, build, soft FM, hard FM, and service provision do not align to provide a cohesive end-to-end solution that meets HCF needs.	• Agree on contracts that incentivise provider alignment • Undertake careful contractual management and oversight to clearly define and manage accountability. • CID appointed to oversee the infrastructure delivery process and consider using the experience to manage the assets post construction so that MSD can hold a single entity to account for delivering an end-to-end solution that meets HCF needs.								

Characteristics	Description	
Design and build work costs more than planned	A delay in the business case and development process could lead to increased costs and impact viability of the preferred option.	- Secure property early while property market favours buyers - Maintain momentum on business case process - Sign contracts early at agreed fees that aren't subject to change with market conditions.
Funding not (fully) approved	Risk that some or all funding is not approved given current government fiscal constraints.	- Focus on benefits, justifications and Chief Ombudsman's recommendations within the PBC and DBC - Prioritise investment so that a reduced budget can be used for highest value improvements.
Inability to purchase RIDSAS facilities and land	Risk that the Crown cannot purchase existing RIDSAS facilities and land, changing the preferred option, increasing investment risk and delaying the programme.	Engage with property owners early to understand and mitigate issues with land purchases.
Resource consent not obtained	Programme being unable to obtain resource consent for refurbishments or construction may result in changes to sites and designs and lead to programme delays and cost escalation.	- Conduct thorough investigations into existing sites to understand site and resource consent limitations - Consult with councils and site stakeholders early.
Government direction and decisions change	The government direction and decisions on HCF changes, adversely impacting the ability to start or complete this work and meet statutory obligations and provide safe care for people under the HCF.	- Develop Communications and Engagement Plan to communicate planned investment to ministers and government decision-makers - Modify subsequent business cases to incorporate changes.
Supply and workforce shortages	Supply and workforce shortages could impact all packages of service – design, build, hard FM, soft FM and service provision potentially causing delays and cost escalations.	- Complete detailed market sounding to understand market constraints - Understand local and regional labour market trends - Consider other options, such as off-site manufacturing options.

4.2 Procurement Strategy

The Preferred Option is comprised of five tranches, commencing in early 2027 through to 2035 and beyond. This Commercial Case focuses on the commercial approach for Tranche One, given the early stage of the programme and ongoing conversations with key stakeholders and potential delivery partners. As such, there is a desire to retain flexibility and respond to changes and/or new information as the programme progress.

MSD, as the agency responsible for providing Disability Support Services (DSS), will not procure or deliver all of the capital assets in this PBC. The HCF involves several government agencies working together, including MSD, Health New Zealand, and Kāinga Ora. The procurement approach is informed by the most recent:

- The Principles of Government Procurement²¹ and the Government Procurement Charter.²² These principles apply to all procurements.
- The Government Procurement Rules.²³ These rules state that agencies must apply the Construction Procurement Guidelines, where appropriate, when procuring construction works.
- MSD and CID's procurement policies.

In July 2025, the Government implemented a mandate for selected agencies, including MSD, to partner with Crown Infrastructure Delivery (CID) for the delivery of their infrastructure investments (Treasury circular 2025/11). CID has strong experience with procurement and vendor management for capital delivery and exists to support capital delivery for Ministries without capital delivery experience, and has demonstrated success in delivery and asset management handback.

MSD has signed a Services Agreement (SA) with CID for them to provide expertise and support in the procurement and/or delivery of RIDSAS facilities. The procurement strategy will be further developed with CID as part of the DBCs.

Other agencies, such as the Department of Corrections and Kāinga Ora, may also be able to provide expertise and support in the procurement, delivery or ownership of RIDSAS facilities. As such, this Procurement Strategy outlines the approach that MSD and CID will take to achieve the desired objectives, with further decisions required as part of the DBCs.

The commercial approach for the programme includes multiple procurements across sequential tranches. Procurement routes will be selected based on programme scope, timing, and market conditions to optimise value for money and minimise risk.

The procurement approach will be further informed by the indicative approach for Tranche One developed through a workshop on 15 May 2025, where key MSD representatives discussed and agreed the framework for determining the preferred commercial option to deliver RIDSAS facilities, as outlined in **Table 39**.

Table 39: Commercial Delivery Framework

Step	Description
1. Identify Assessment Criteria	Identify the commercial factors that are most important to MSD and the HCF Framework.
2. Develop Packaging Options	Consideration of the services that would be most appropriate to group together to deliver the RIDSS and RIDSAS facilities. These services included: design, build, soft FM, hard FM, and service provision.
3. Identify Ownership Scenarios	Identify the possible ownership scenarios for the RIDSAS facilities and outline potential considerations/risks associated with each scenario.
4. Identify Responsible Parties	For each ownership scenario, determine which agencies and/or private sector actors should be responsible for delivering each service package.

4.2.1 Procurement Criteria

²¹ [Government procurement principles | New Zealand Government Procurement](#)

²² [Government Procurement Charter | New Zealand Government Procurement](#)

²³ [Government Procurement Rules | New Zealand Government Procurement](#)

Table 40 outlines the procurement criteria agreed with key MSD stakeholders on 15 May 2025.

Table 40: Procurement Evaluation Criteria

Criteria	Description
1. Control	Provides the Crown with sufficient control to ensure facilities are delivered, operated, and maintained to appropriately support care provision for people living in the HCF. Control also means supporting future flexibility to transfer access / change service commissioning where this may be needed.
2. Quality Service Delivery	Supports provision of quality services to meet the specialised needs of people living in the HCF.
3. Asset Condition	Best supports long-term asset condition, given the HCF environment likely requires assets and asset maintenance suited to a high-impact environment.
4. Security and Safety	Supports a secure and safe environment for clients, staff and public throughout delivery and operation (in alignment with the SSM).
5. Market Capacity and Capability	Provides the required market capacity and capability to deliver the services to the required quality standard, within the allocated time, budget, scope and risk tolerances.

4.2.2 Packaging Options

To support establishing a potential delivery model for Tranche One, initial packaging options were developed to determine how key project components could be delivered together (or separately) to provide value for money and best achieve MSD's objectives.

Packaging of project components can offer advantages over individually considered contracts, including:

- **Greater Value for Money:** In instances where it is logical to bundle services, there is potential for significant savings resulting from better risk alignment. For example, a single service provider responsible for managing risk can generate savings through more effective design and construction that limits ongoing operational and maintenance costs.
- **Competitive Tension:** 'Larger' procurement opportunities could incentivise more parties to engage in the procurement process. Generally, strong market interest drives competitive tensions on price and quality of responses, generating better value for money.
- **Lower Costs:** A streamlined tender process could lower costs for the government and the market. A smaller number of large contracts may have lower administration costs compared to a greater number of smaller contracts. There is potential to leverage replicable Request for Proposals (RFPs) and other procurement documentation. As above, this can result in cost efficiencies in the development of procurement material.

Professional Services Contracts

It is expected that many professional services will fall within broader contracts for the preferred packaging option. For example, engineering advice or specialist alarm system installation and maintenance could be part of the contracts relating to design, build, and hard facilities management.

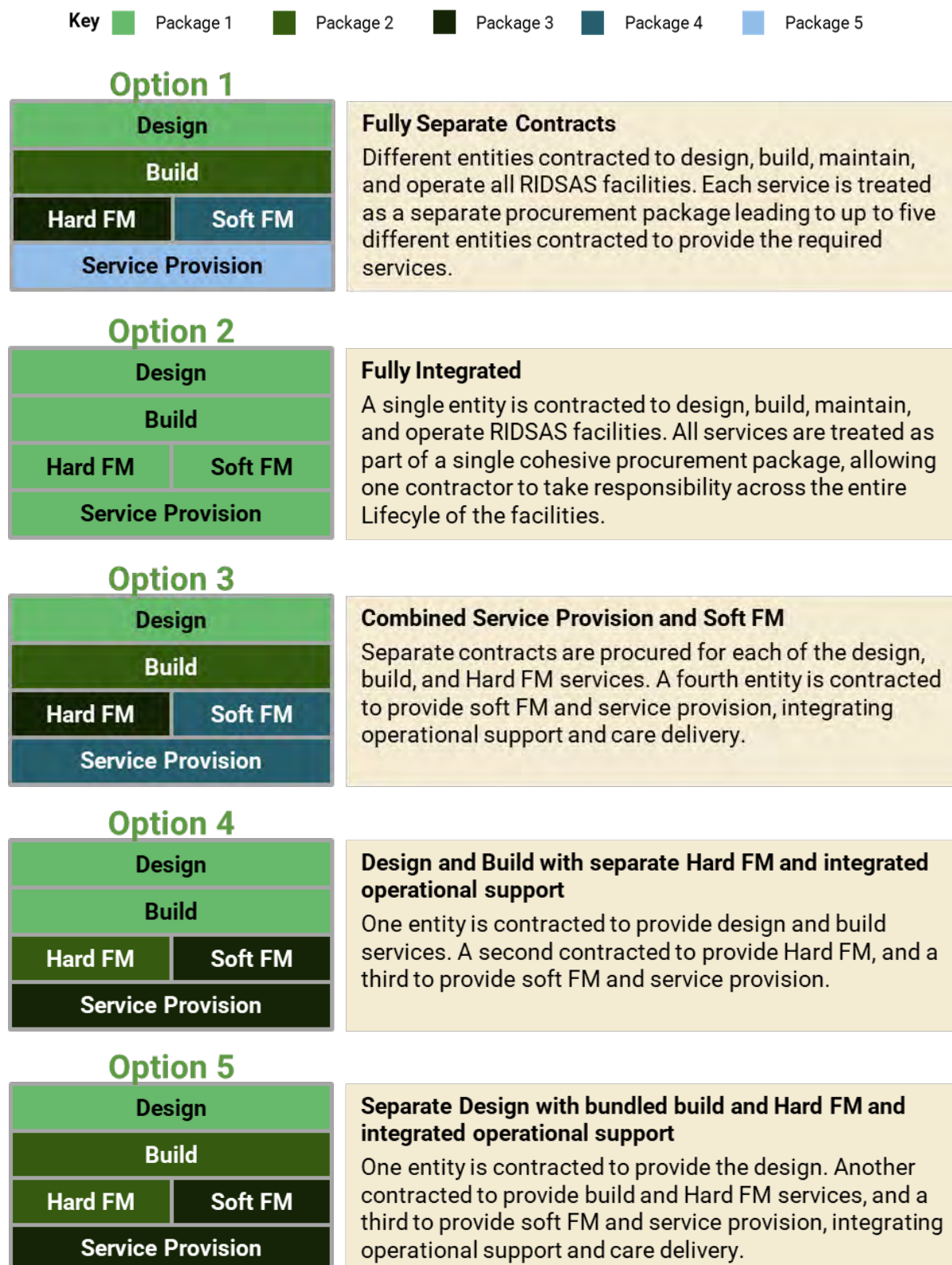
Some professional services, such as legal, project management, and quantity surveying, may be contracted separately so that there is direct accountability to the contracting government agency. This will be evaluated and clarified further in the DBC.

Packaging Options

For the design, build, facilities management, and support services, a longlist of six options was developed and assessed against the procurement criteria outlined in **Section 4.2.1**. These options are graphically

presented in **Figure 23**, with each different colour representing a single procurement package. For example, Option 1 consists of five separate procurement packages, whereas Option 2 consists of one single procurement package.

Figure 23: Six Packaging Options



Option 6

Design	
Build	
Hard FM	Soft FM
Service Provision	

Combined Maintenance

Design, Build, and Service provision are procured as separate contracts (three entities).

Hard and Soft FM services are packaged together and procured as a separate contract.

Packaging Assessment

Each longlist option was assessed against the criteria, with scores ranging from 'Very Poor' to 'Very Good' (as illustrated in **Table 41**) to determine the preferred packaging approach. This assessment has been summarised in **Table 42** with further details provided in **Appendix W**.

Table 41: Scoring Scale

Very Poor (-2)	Poor (-1)	Average (0)	Good (+1)	Very Good (+2)
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Table 42: Packaging Assessment Summary

Criteria	Option 1	Option 2	Option 3	Option 4	Option 5	Option 6
1. Control	1	-1	2	1	1	2
2. Quality Service Delivery	0	-1	2	0	1	1
3. Asset Condition	1	2	1	1	0	0
4. Security and Safety	0	-1	1	0	1	0
5. Market Capacity and Capability	1	-2	2	1	0	1
TOTAL	3	-3	8	3	3	4

Preferred Packaging Option Overview

Option 3 includes procurement of separate contracts for each of the design, build, and hard FM services. Soft FM and residential support services are packaged together to integrate support and care delivery. The key components of this option are outlined below:

- Design Package:** One contract is let for the design of the facilities. The provider is responsible for creating designs that meet the necessary requirements and standards, ensuring that the facilities are secure, safe, accessible, and homelike.
- Build Package:** A second contract (which could be a separate contract or a part of a delivery consortium) is let to oversee the construction of the facilities. The contractor is responsible for executing the design plans and delivering the facilities according to the specified standards and timelines.
- Hard FM Package:** A third contract is used for providing hard FM services, which include the maintenance and management of the physical infrastructure. The provider(s) ensures that the facilities are kept in good condition and that any necessary repairs or upgrades are performed efficiently.
- Soft FM and Service Provision Package:** A fourth service provider is engaged to provide soft FM services together with resident support services. The soft FM services will encompass operational support functions such as cleaning, landscaping, and waste management. The resident support service provision will include services to smoothly operate the facilities, keep residents safe and secure, and integrate with day-to-day living in care (e.g. assistance with cooking and laundry). It should be noted that residents are encouraged to live as independently as possible, so this package does not provide catering, laundry services or other living services as such, although staff may assist where required, as residents perform these tasks. Some parts of this package could be sub-contracted by the main service provider to other contractors (e.g. for cleaning or landscaping) or could be delivered directly by the service provider.

The preferred option is Option 3. Option 3 enables each package to be delivered with appropriately specialised expertise and service quality standards, while also appropriately supporting care provision for people living in the HCF.

CID will act for MSD and be the principal to RIDSAS contracts for Design, Build, Hard FM and potentially Soft FM. CID would contract on MSD's behalf with the specialist suppliers required, such as architects for design and main contractors for construction. CID is not well placed to manage the delivery of commissioned services, and given the specialist nature of this service, it would not be appropriate. Delivery of HCF services would remain the purview of MSD, through the established relationships with Health New Zealand and NGO HCF service providers.

How projects are packaged is closely linked to the market's ability to deliver. As these are highly bespoke facilities, further research will be undertaken as part of the DBC to ensure that packaging options remain appropriate, with consideration given to value for money, administrative burden, and risk allocation.

4.2.3 Facility Ownership

Facility ownership will have an impact on which agency(ies) may be best placed to take responsibility for managing the procurement process for each of the different packages (as discussed in **Section 4.2.4**).

Private Sector Ownership (Status Quo)

Currently, RIDSAS facilities do not have consistent ownership. In some cases, RIDSAS facilities are owned by current RIDSAS service providers or rented by service providers from the private residential market. A smaller proportion is owned by Kāinga Ora and leased by RIDSAS service providers.

The current fragmented system is unsustainable. Early engagement with National Infrastructure Funding and Finance Co. highlighted the potential for consolidating RIDSAS ownership to a single private sector provider.

However, MSD considers that it makes the most sense for the government to own – or otherwise control – the physical assets for the HCF. Continued control of the facilities by the HCF service providers:

- Risks 'lock in' to a single provider who owns or has possession of the HCF facilities (unless alternative suitable properties and service providers can be found and the residents moved)
- Does not provide long-term asset retention security and access to specialised facilities required by the HCF
- Does not provide the flexibility, access, and facility standards required to maintain high quality service delivery to the HCF
- Is unlikely to meet the future objectives of the HCF.

Crown RIDSAS Ownership

To preserve flexibility and optionality, MSD considers that the new or refurbished, bespoke RIDSAS facilities are best owned by or leased by the Crown. MSD has not historically owned facilities and as such may not be the most suitable government agency to own the RIDSAS facilities on behalf of the Crown. Other government agencies, with experience in residential or facility asset ownership, may be more suitable for this role.

The most suitable candidate for RIDSAS ownership will be evaluated further in the DBC.

4.2.4 Procurement Management Responsibility

In line with the roles and responsibilities set out in Treasury Circular 25/11 – The Crown Infrastructure Delivery Mandate, MSD will delegate authority to CID to lead procurement for Tranche One RIDSAS

facilities.²⁴ CID will act as principal to the construction contracts associated with this investment. CID is an agency with extensive commercial and procurement capability and will carry out procurements in line with its best practice. The lead agency for future services contracts will be determined by the JAGG and set out in future DBCs.

Future DBCs will consider the appropriate lead for the procurements associated with this investment. MSD consider that HNZ is best placed to manage and deliver improvements to RIDSS facilities. HNZ's approach to procurement will be aligned with their organisational policies and will be set out in more detail in future DBCs for those tranches involving RIDSS improvements.²⁵

4.2.5 Approach to Market

On the basis of the potential supplier market, the relative value of the procurement, the different types of services required (refurbishment, new-build) and the complexity of the HCF, it is likely that a blend of procurement approaches will be needed for this programme:

- New-build RIDSAS and refurbishment of RIDSAS facilities, due to their small scale and highly specialised nature, may use a closed tender process.
- Services and operating contracts, due to the small number of existing providers and the specific risk profile of the services involved, may involve direct sourcing using current providers.

The scale and cost of this proposal are likely to make it of limited attractiveness to the open market. Early supplier engagement is planned to test market interest, understand capability, and inform future procurement planning.

Subject to approval and to further market assessment, CID proposes to approach the market with an RFP for capital works and direct sourcing for services.

4.3 Contract Provisions

Suitable contractual arrangements will need to be established with providers. Separate contracts will be needed for each package relating to design, build, hard FM, and soft FM, together with service provision. In Tranche One, work will be performed in both the Northern and Central Regions and it is likely that separate contracts will be required across each of these regions.

CID will partner with MSD to deliver the RIDSAS facilities. CID will manage the contracts with suppliers for design, build, and hard FM, using standard delivery agreements.

The MSD-CID delivery agreement will set out how CID will provide services, including procuring and engaging any third-party suppliers required by CID to support the provision of the services for MSD. Before engaging a third party, CID will obtain MSD's prior written approval for any estimated costs associated with engaging such third party.

In engaging a third-party, CID will:

- ensure appropriate due diligence is undertaken, including the identification and management of conflicts of interest, and that any procurement process is consistent with the Government Procurement Rules and best practice;
- ensure that the third party is fully aware of the obligations of CID under this Services Agreement and that any contract for service is on terms consistent with this Services Agreement;

²⁴ [Treasury Circular 2024/19: The Crown Infrastructure Delivery Limited Mandate](#)

²⁵ [Procurement – Health New Zealand | Te Whatu Ora](#)

- ensure that any third party carries all appropriate and usual insurances for a consultant in their field providing services similar to the Services.

4.3.1 Forms of Contract

It is likely that a variety of different contracts (e.g. professional services, construction, etc.) will be required to deliver the programme of RIDSAS and RIDSS builds. MSD expects New Zealand Standard Form contracts (e.g. *NZS3910: Conditions of Contract for Building and Civil Engineering Construction*) will be used as these are widely understood and used by the industry. Contracts may be amended to encompass circumstances particular to the works associated with each project, given the specialised nature of the facilities.

4.3.2 Contract Length

The following sections set out the expected contract duration for the contracts associated with each package of design, build, hard FM, and service provision, together with soft FM services. This Commercial Case proposes separate, rather than combined, design contracts and build contracts.

Design Contracts

Design contracts for RIDSAS facilities are expected to be approximately 6 months per facility for both refurbishment and new build design. Design contracts will look to standardise facilities as much as possible to achieve efficiencies and reduce contract lengths for subsequent new build RIDSAS facilities. Further DBCs will consider whether approaches such as modular solutions can be designed to save time and processing fees during consenting processes.

Design contracts for RIDSS facilities are expected to be up to 9 months per facility. This longer duration (relative to RIDSAS facilities) is to accommodate the more bespoke nature of design required for builds on existing, operational hospital sites and the more specialised nature of these facilities.

Build Contracts

The contracts for the refurbishment and construction of Tranche One RIDSAS facilities are expected to commence in October 2027. Construction duration is expected to be completed in June of 2030, providing an approximate duration of two years and nine months. Noting that each RIDSAS facility refurbishment or construction is estimated at 12 months in length. Wherever possible, refurbishment and construction contracts will be bundled to achieve efficiencies and economies of scale, which may be at a regional or national level.

Hard Facility Management (FM) Contracts

The contract for hard FM for Tranche One should begin in FY30 in the Northern Region and FY31 in the Central Region, and should be a long contract period, such as 10 years. Each contract should also cover all RIDSAS in a particular region, noting that existing RIDSAS facilities likely already have existing hard FM contracts. The long duration and regional coverage enable providers to become familiar with and sensitive to the specific needs for RIDSAS environments, relating to buildings, systems, residents and security. This long contract period is consistent with Department of Corrections contracts for correctional facilities, where familiarity with the specific needs helps hard FM services be delivered consistently, safely and efficiently to the required standard.

Service Provision and Soft Facility Management (FM) Contracts

The contract for service provision and soft FM for Tranche One should begin in FY30 in Northern Region and FY31 in Central Region. The contract length should be 5-10 years. Note that service provision and soft FM contracts are in place today for existing RIDSAS facilities. No changes are proposed to these providers or contracts for existing facilities as part of this PBC. Contracts may enable providers to subcontract specific specialist services where agreed with the contracting government agency.

4.3.3 Proposed Contractual Clauses

Depending on the nature of the contracts, they are likely to include:

- The scope of work/service
- Security (e.g. contractors' bond)
- Intellectual property
- Health and safety, and quality specifications
- Indemnity
- Insurances including contract works, public liability, and professional indemnity
- Change management (variations)
- Time for completion, including liquidated damages
- Defects liability, warranties, and guarantees
- Terms of subcontracting
- Payment (including a retentions regime)
- Dispute resolution
- Default
- Termination

4.3.4 Potential for Risk Sharing

Early conversations with National Infrastructure Funding and Finance Co have confirmed that the size and nature of these contracts are not suitable for traditional public private partnership contracts. The structure of the preferred packaging option (option 3), where there is very little bundling of services, and in particular design services being separate from build services, also means there is less scope for risk sharing in these contracts. This makes sense given the specialised nature of the RIDSAS facilities, where needs are very specific, and service provision requirements are likely to be variable. Service providers may be less receptive to sharing risk in this specialised and variable environment. This should be looked at further in the DBC to continue to explore opportunities for risk sharing.

4.3.5 Payment Mechanisms

The payment mechanism will need to be determined by the owning government agencies for each tranche and facility type. However, potential payment agreements may include:

- **Design contracts:** monthly payment for services delivered.
- **Build contracts:** payment upon milestone delivery accepted by the contracting government agency. Some components of payment may be monthly for work completed during the month, with inclusion of an appropriate retention. This approach is reasonably standard within the construction industry.
- **Hard FM contracts:** standard monthly payment for routine maintenance schedule, plus additional fees for required ad-hoc maintenance and services, as well as minor capital works.
- **Service provision and soft FM contracts:** this will remain consistent with MSD's current approach, where payment is made monthly based on an agreed rate per number of beds and number of days (bed day rate). This will be based on the HCF standard bed day pricing rates. Note that the pricing rates may need to be modified to reflect the different scenario with future RIDSAS facilities having Crown ownership as well as the inclusion of soft FM services in the rates.

4.3.6 Accountancy Treatment

The contractual arrangements are proposed to use standard contracts and not public private partnerships. As such, no unique accountancy treatment is expected to be required, and instead, it is suggested that the funding government agencies apply their standard accountancy treatment. The RIDSAS facility assets will sit on the owning government agency's balance sheet.

5. Financial Case

5.1 Introduction

This Financial Case provides an initial assessment of the overall affordability and potential fiscal implications of investing in the **Preferred Option** identified in the Economic Case: Option 4 – Care Continuum through New Build.

An overview of the capital and operating costs of the **Preferred Option** over a 25-year delivery and operations period is set out in **Table 43**. A breakdown of total capital costs by tranche is set out in **Table 44**, and a breakdown across financial years is set out in **Table 45**. Further details on all costs are set out in the Financial Case.

Table 43: Summary of Preferred Option Costs - Option 4

s9(2)(j)

Table 44: Summary of Preferred Option Capital Costs - Option 4, by Tranche

s9(2)(j)

Table 45: Summary of Incremental Costs for Tranche One

s9(2)(j)

For this PBC, the financial analysis does not constitute a detailed analysis of the funding required. A more detailed analysis will be performed and presented through formal requests for funding in subsequent

²⁶ Includes Land Acquisition Costs (Scenario One).

²⁷ Includes Depreciation and Capital Charge.

business cases. These business cases will provide more granularity and certainty over the associated capital and operating costs.

As the delivery option preferred by MSD and endorsed by JAGG, Option 4 (Care Continuum through New Build) is the focus of this Financial Case. This reflects the current preference for a decentralised delivery model. However, the financial analysis for the second ranked overall option and preferred centralised delivery option, Option 7 (RIDSS Centralisation), is provided in **Appendix Y**.

5.2 Cashflow Forecast

Overview of approach

The estimated costs of the Preferred Option were determined through the development of a Financial Model (the Model), which incorporates the capital and operating costs of all components of the proposed investment. In preparing the Model, inputs and assumptions were sourced from DSS, Treasury and technical experts.

Key inputs and assumptions

The costs of the Preferred Option comprise:

- Capital costs for the development, procurement, design and construction of the HCF RIDSS, Stepdown and RIDSAS facilities; and,
- Operating costs related to the ownership of the facilities, including maintenance, depreciation and capital charge.

A summary of the key inputs and assumptions in the Model, and their respective sources, is provided in **Appendix Z**.

Land acquisition costs

Under the Preferred Option, a small number of new-build RIDSAS facilities can be either:

- (a) rebuilt on **existing provider owned land** acquired by the Crown or
- (b) built on **new sites** acquired by the Crown.

As outlined in the Economic Case, this choice means there are two variations of the Preferred Option – Option 4a and 4b. At this stage, it is assumed that the Crown should own all RIDSAS sites (either existing provider/Crown owned sites or new sites) that receive capital investment through this programme to reduce future 'stranded' investment risk to the Crown. **Table 46** summarises these land acquisition variations.

Table 46: Land Acquisition Scenarios

Land Acquisition Scenarios	Description
Variation A: Purchase existing RIDSAS sites for new builds where feasible (Option 4A and 7A)	Under this variation, the Crown acquires all existing RIDSAS sites that receive capital investment (refurbishment or rebuild) that are not already Crown owned. Where necessary, the Crown will acquire new land for new RIDSAS builds where it is not possible to build on existing land.
Variation B: Purchase new RIDSAS sites for new builds (Option 4B and 7B)	Under this variation, all new build RIDSAS facilities are built on new sites acquired by the Crown and no new RIDSAS facilities are rebuilt on existing provider owned or leased land. If a RIDSAS facility is refurbished, the Crown is assumed to purchase the existing site from the Provider/owner if the site is not already Crown owned.

Subsequent business cases will explore the feasibility of building new RIDSAS facilities on existing RIDSAS sites and the viability of purchasing existing sites from RIDSAS providers. Based on this information, the variants of Option 4 presented in this Financial Case will likely evolve, resulting in a 'hybrid' version of the A and B variations outlined. However, the cost implications of these variants in this PBC allow the programme to remain flexible before subsequent business cases explore these options in more detail.

Practically, acquiring existing sites may be somewhat more expensive, as they are owned by providers or existing private landlords who already provide RIDSAS services to MSD, and this demands a cost premium. Those existing sites are already well-known and understood, and house existing clients, so **Variation A** is

used as the preferred variant in this Financial Case to represent the estimated maximum investment required. Variation B: Use new RIDSAS sites for new builds is presented as a lower range estimate in Section 5.4.

Summary outputs of the financial model

Based on Cost Variation A, the estimated present value (PV) for the Preferred Option is s9(2)(j)

This figure is based on a 25-year appraisal period between FY27 and FY52. The capital costs include all costs required to deliver the project, with escalation applied in line with construction estimates. Operating costs have been escalated per the CPI and LCI rates detailed in **Appendix Z**.

To determine the PV, all nominal costs have been discounted at a rate of 4.50% per annum to analyse the actual dollar amounts that will be paid in the future. These rates are consistent with Treasury guidance.²⁸

Section 5.2.1 of this Financial Case presents the total incremental capital and operating costs of the Preferred Option. This separately identifies the capital, operating and depreciation costs over the appraisal period in nominal terms.

These costs will be further refined through subsequent business cases.

²⁸ Sourced from Treasury New Zealand – “Discount Rates and CPI Assumptions for Accounting Valuation Purposes”

5.2.1 Annual Capital and Operating Requirements (nominal)

Table 47: Option 4: Annual Capital Funding Requirements (nominal) (totals may not sum due to rounding)

Table 48: Option 4: Annual Operating Expenditure Cashflows (nominal) (totals may not sum due to rounding)

Table 49: Option 4: Incremental Whole of Life Costs (nominal)

5.3 Summary of Preferred Option Component Costs

5.3.1 Capital Costs

Table 50 provides a breakdown of the total capital cost (nominal) of the Preferred Option. Expenditure has been informed by the quantity surveyor estimates and land acquisition cost estimates, presented at the facility level.

For a comprehensive breakdown of capital costs for each facility, based on the cost components detailed above, please refer to **Appendix Q**. This appendix also highlights the components that are excluded from the QS capital costs estimates (e.g., demolition costs, resource consenting, and management reserves).

Table 50: Capital Costs of Option 4 - Care Continuum through New Build (totals may not sum due to rounding)
s9(2)(j)

5.3.2 Operating Costs

Incremental bed capacity

Incremental operating costs are associated with the increased number of beds, and the increase in maintenance costs associated with new facilities.

This PBC presents a capital investment program that includes both the replacement and refurbishment of existing facilities, as well as the construction of new capacity. New build facilities either replace existing

capacity (where a new facility is set to replace one that will no longer be used for HCF services) or add new capacity to the system.

Table 51 summarises the impacts of the Preferred Option on RIDSS and RIDSAS capacity in terms of the number of end state beds available in the system by facility type. It is the number of new beds available that drives the incremental operating costs for each option.

Table 51: Option 4 - Incremental bed capacity, by facility type

Incremental Operating Capacity (additional to BAU) – Option 4				
	RIDSS	Stepdown	RIDSAS	Total
Existing Capacity	40 beds	12 beds	39 beds	91 beds
New Capacity	19 beds	10 beds	10 beds	49 beds
Total Capacity	59 beds	22 beds	49 beds	140 beds

Asset specific operating costs

Table 52 presents the increased operating costs, relative to business-as-usual, incurred by investing in Option 4. Overall, this investment will result in a ^{sg(2)(j)} incremental increase in operating costs over the 25-year appraisal period under **Option 4**.²⁹

The asset specific operating costs relevant to the HCF facilities are as follows:

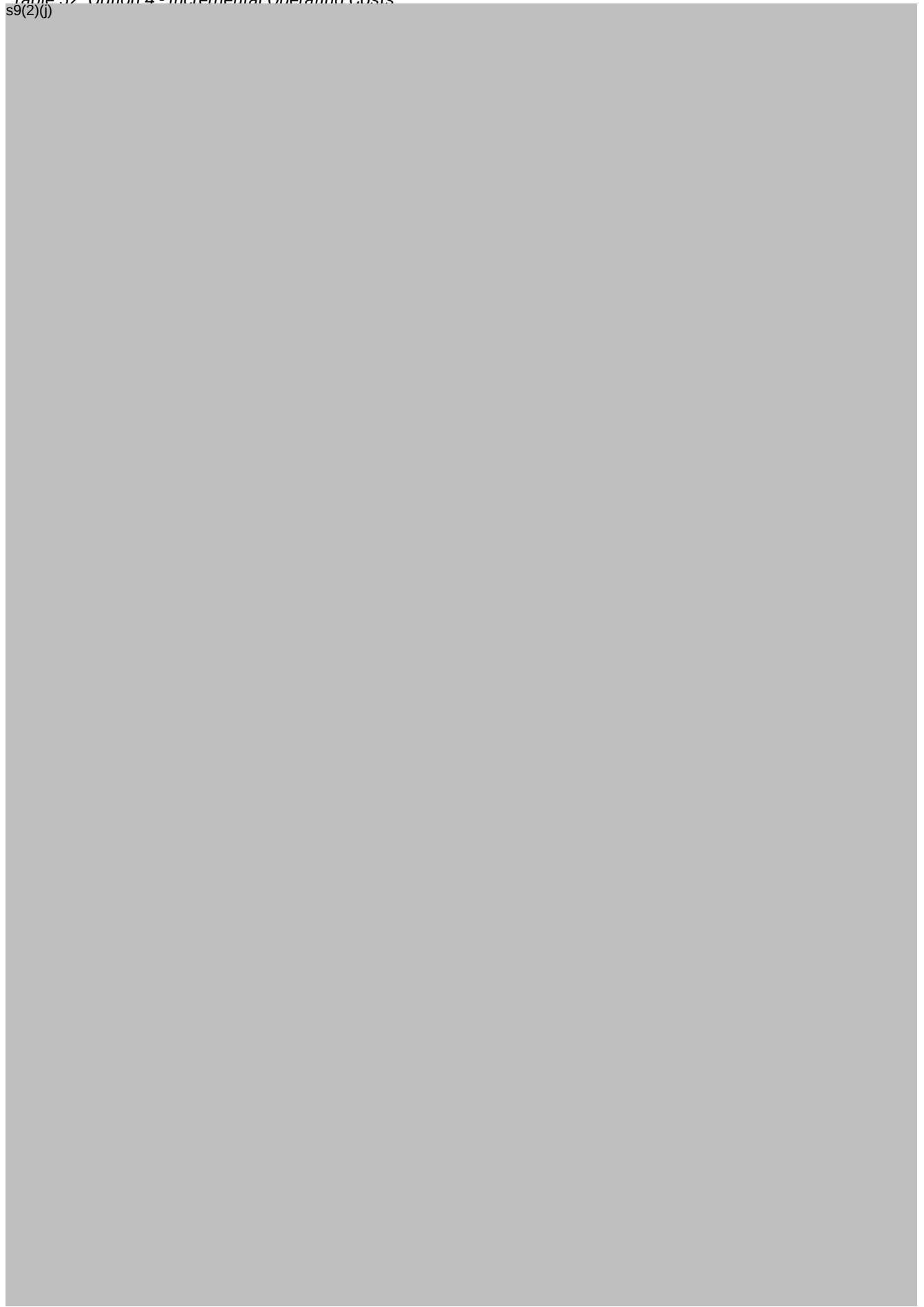
- **Staffing Costs:** This category includes all expenses related to personnel, such as staffing for the direct provision of care, and includes additional costs associated with sleepovers and care coordination to ensure comprehensive support for client care.
- **Client Related Expenses:** These expenses cover medical expenditures and essential supplies, including food and household items, directly contributing to the care and comfort of clients.
- **Non-Client Related Expenses:** This category encompasses costs for transportation, rent, and utilities to maintain operational facilities and supporting staff.
- **Overheads:** Overhead costs include management, administration, and operational expenses such as office rental and equipment, to ensure the functioning of the organisation.
- **Maintenance:** This category covers expenses related to the upkeep and repair of facilities and equipment, ensuring a safe and functional environment for both staff and clients.
- **Depreciation:** Depreciation accounts for the reduction in value of physical assets over time, reflecting the wear and tear on equipment and facilities used in operations.
- **Capital Charge:** Per *Crown Entities (Capital Charge Rules) Regulations 2011*, this category represents the cost of utilising capital assets, including interest and opportunity costs associated with New Zealand Government investments in infrastructure and equipment. An annual capital charge of 5.00% has been applied to the capital injections sought to proceed with the preferred option.

The key drivers for the increases in operating expenditure include:

- The differences in construction schedules of the HCF facilities over the 25-year appraisal period.
- Inflation and real wage increases
- Increased capacity to RIDSS, Stepdown / Cottage and RIDSAS facilities, supporting greater care recipient volumes.

²⁹ The operating costs outlined below reflect the estimated expenditure associated with Variation A. This includes the assumed land acquisition cost premium for purchasing existing sites, which affects the related Capital Charge. Variation B operating costs are presented as a lower range estimate in Section 5.5.

Table 52: Option 4 - Incremental Operating Costs
s9(2)(i)

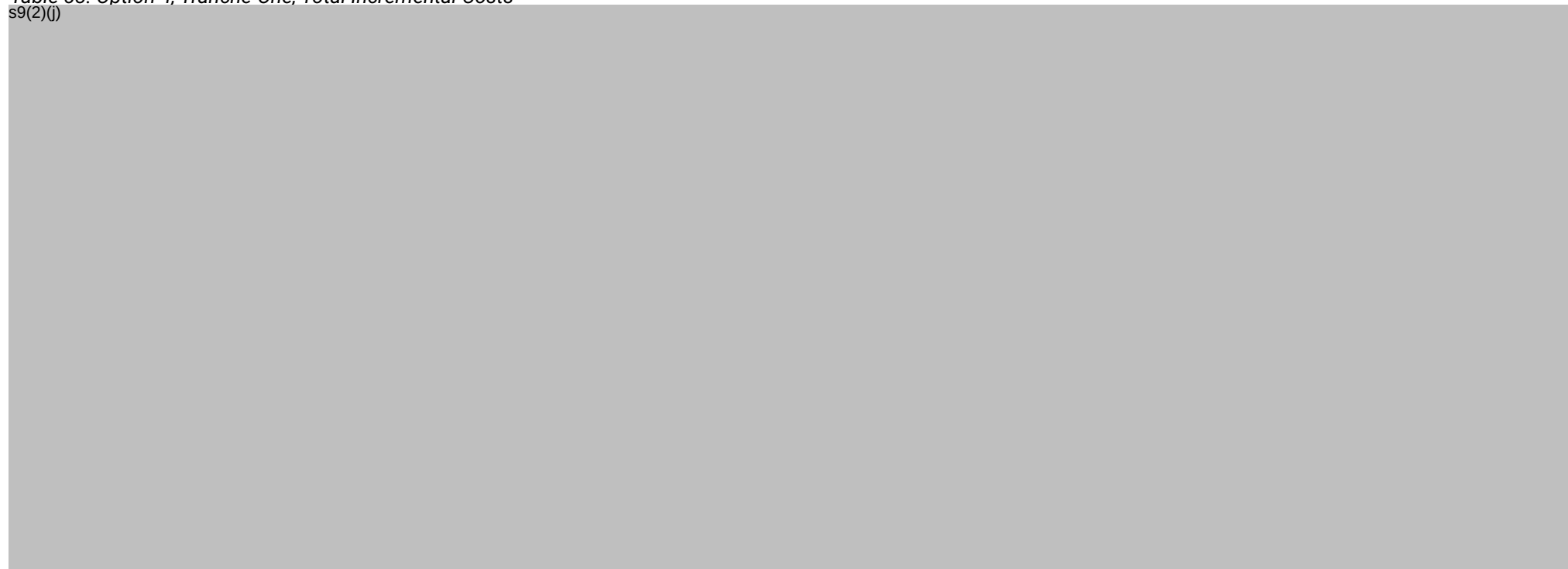


5.4 Funding the Preferred Option

The total HCF programme is anticipated to have a **capital cost of s9(2)(j)** under **Option 4: Care Continuum through New Build**. Following approval of this PBC, subsequent business cases will be developed to draw down the capital required. The first business case will focus on delivering Tranche One and confirming Option 4 as the preferred approach. **Table 53** outlines the capital and operating costs associated with Tranche One only. The cost of delivering the entire programme is shown in **Table 54**.

The Tranche One capital cost reflects the capital cost associated with a selection of RIDSAS facilities in the Northern and Central regions. For Option 4, the first full year of operations (FY31) has an incremental operating cost of **s9(2)(j)**, reflecting the incremental cost of operating two new facilities providing additional capacity, the refurbishment of an existing facility, and the replacement of an existing facility with a new build. Option 4 has a total incremental operating cost over 25 years of **s9(2)(j)**. The total incremental costs for Tranches 2-5 are outlined in **Appendix X**.

Table 53: Option 4, Tranche One, Total Incremental Costs
s9(2)(j)



For the purposes of this PBC, it is assumed that the **total incremental operating costs of** ^{s9(2)(j)} **under Option 4** (nominal, over 25-years) will be incurred progressively following facility construction. This PBC proposes a phased approach to funding that will seek capital funding through an initial bid to facilitate initial land acquisition.

Fiscal implications

The difference in the overall capital cost between the variations of Option 4 is largely driven by land acquisition optionality and programming differences. While the Financial Case has presented the upper limit of the Preferred Option capital costs through Variation A: Use existing RIDSAS sites for new builds where feasible (Option 4A), **Table 54** demonstrates the estimated funding range depending on the land acquisition scenario.

Table 54: Funding Option 4 - Land Acquisition Scenarios

^{s9(2)(j)}

5.5 Next Steps

Following approval of this PBC, subsequent business cases for the first phases of capital investment in the programme will be progressed. The subsequent business cases will then further develop detailed capital, operating, and maintenance costs for the selected Preferred Option, along with a quantitative risk assessment outlining the cost risks associated with the level of design to which the Preferred Option is progressed. The cost to develop the subsequent business cases will be funded by MSD and sits outside this funding request.

Subsequent business cases will explore the feasibility of building new RIDSAS facilities on existing RIDSAS sites and the viability of purchasing existing sites from RIDSAS providers. Based on this information, the variants of Option 4 presented in this PBC will likely evolve, resulting in a 'hybrid' version of the A and B variations outlined in this PBC. However, outlining the cost implications of these variants in this PBC allows the programme to remain flexible before the subsequent business cases explore these options in more detail.

6. Management Case

6.1 Introduction

This Management Case describes the arrangements that are and will be put in place for the successful delivery of the HCF programme.

As the commissioning agency for DSS, including the HCF, this updated PBC assumes that MSD will be the lead agency for this investment in RIDSS and RIDSAS facilities. MSD's capital asset delivery function is still maturing, which reinforces the need for clear governance, delivery support, and assurance arrangements as part of this business case. MSD-DSS has entered into a services agreement with Crown Infrastructure Delivery Limited (CID), a Crown-owned company that specialises in infrastructure delivery to support the delivery of RIDSAS facilities for tranches 1, 3, and 4 of this programme (see section 6.6.2 below for details on proposed tranches).

This updated PBC outlines the existing programme and project management practices in development, as aligned with existing MSD and CID management practices and draft programme delivery documentation. Future Detailed Business Cases for the individual tranches of this investment will be developed by CID (on MSD's behalf) for Tranches 1, 3, and 4 (covering RIDSAS infrastructure), and HNZ for Tranches 2 and 5 (covering RIDSS infrastructure).

As mentioned in the Strategic Case, management, delivery, operation, and stewardship of the HCF is a joint agency responsibility, and this Management Case emphasises the importance of cross agency collaboration and engagement at the PBC stage and as the programme progresses through the investment lifecycle.

6.2 Joint Agency Programme Governance

The HCF Programme has established joint agency governance to authorise, monitor and support the successful planning and delivery of new and refurbished RIDSS and RIDSAS facilities. Following Gate 0 review feedback (see section 6.11 below) the JAGG composition and mechanisms were reviewed and refreshed by MSD-DSS and CID's Programme Director. The refreshed JAGG has been in operation since early 2026.

HCF Programme Governance Objectives

The key governance objectives for the HCF Programme include:

- Providing a clear structure of decision-making and endorsement of key Programme plans and documents
- Fostering active collaboration between MSD and partner agencies to reflect the importance of joint agency responsibility and accountability for the HCF Programme
- Ensuring responsible, accountable and transparent management of the programme through financial controls, regular reporting and active risk management.

Programme Structure and Governance

The HCF Programme organisation and governance structure is outlined in **Figure 24** below. The structure depicts the relationship between the day-to-day programme operations and programme governance (Senior Responsible Owner (SRO), JAGG and Cabinet). **Figure 25** illustrates the future DBC structure and governance.

Figure 2424: Programme and Governance Structure

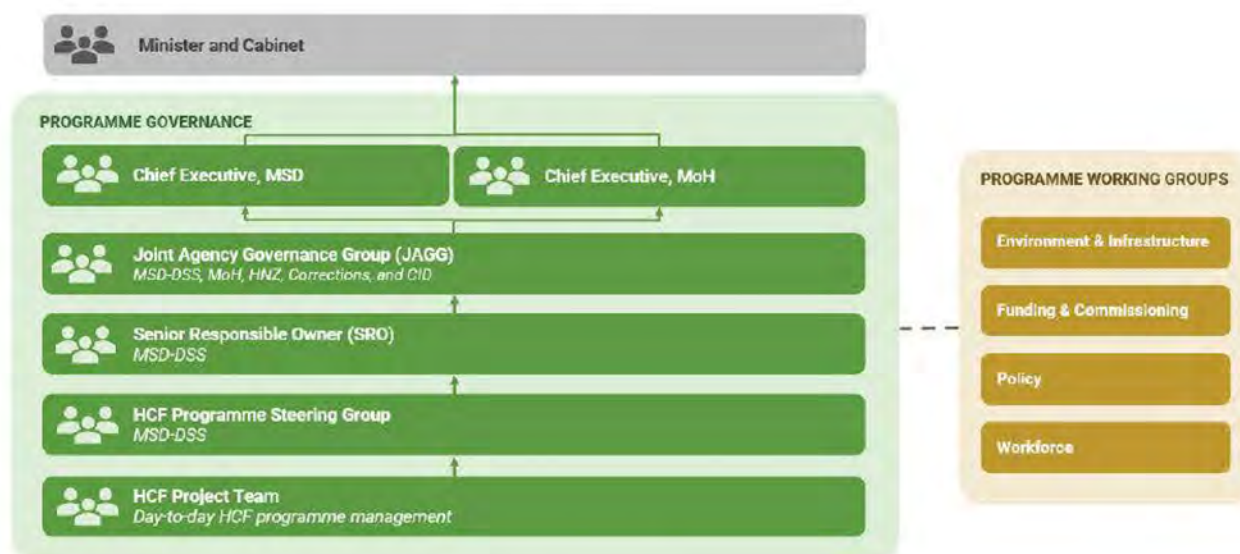
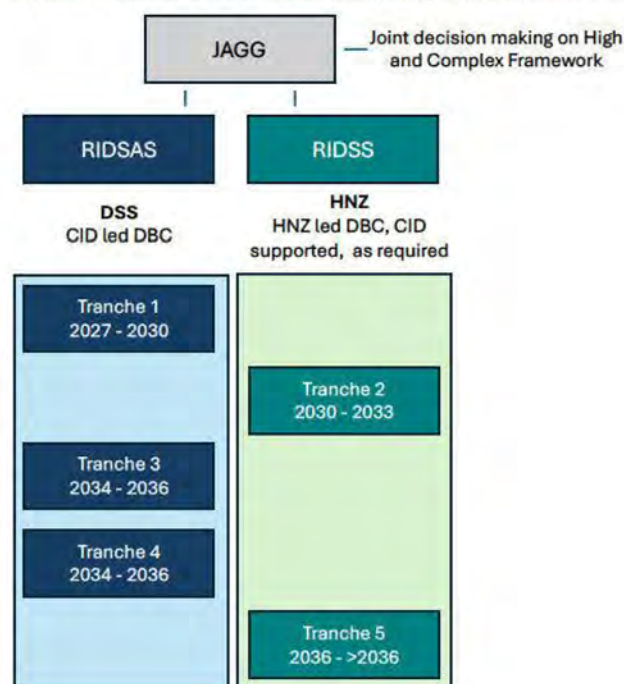


Figure 25: Future DBC Ownership and Governance Structure



Minister and Cabinet

The Crown provides infrastructure funding for major projects through Cabinet and Ministerial decisions, as escalated by the programme governance structure outlined in the diagram above.

Chief Executives of MSD and MoH

Final approval and endorsement of HCF Programme business cases and other key deliverables is provided by the Chief Executives of MSD and MoH. Once this endorsement is provided the business case can proceed to the Minister and Cabinet. Other agencies, such as HNZ, will be involved in approving subsequent business cases.

JAGG

DSS has established the JAGG to steer a multi-year programme of work across agencies to deliver key actions arising from the HCF Action Plan and manage any issues and risks in the delivery of services. This includes governance of this investment in RIDSS and RIDSAS facilities. The JAGG formalises existing cross agency work progressed through the relationships held between leaders in the agencies.

The purpose of the JAGG is to govern the HCF Programme across agencies (MSD and MoH), coordinate agencies that have roles in delivering the HCF, and act as an escalation point for issues and risks.

The JAGG formalises cross-agency governance of the HCF programme with the MoH and HNZ and is responsible for driving, monitoring and reviewing progress against the strategic plan. There is a need to support coordinated steerage of the HCF to ensure that the vulnerable New Zealanders for whom it applies receive high quality and sustainable care.

JAGG is the ultimate decision-making body for the HCF Programme governance structure and provides overall programme direction, strategic advice and leadership. However, JAGG does not interfere with decision rights held by individual agencies and their leadership. Agencies reserve their roles to escalate issues and risks to their CEs or designated leads, including where progress is limited.

The JAGG's composition will be kept under review as DBCs are developed. **Table 55** below outlines the current JAGG membership.

Table 55: JAGG Membership

Organisation (Entity)	Representative
MSD ³⁰	Associate Deputy Chief Executive DSS (Chair)
MoH	Deputy Director General – Strategy and Policy
Health New Zealand	National Director – Mental Health and Addictions
Department of Corrections	Deputy Chief Executive – Pae Ora
Crown Infrastructure Delivery Limited	General Manager – Policy, Communications, and Government Engagement

Attendees reflect individual decision rights for the agencies involved. Commitments made by individuals and agencies should be considered as agency commitments consistent with regular interagency practices.

Some decisions required from this group may require senior leadership authorisation by the respective agencies. As such, the group will make formal recommendations to be progressed through the appropriate authorising structure. Out-of-cycle documents may be circulated for review ahead of the JAGG meetings to enable decision making.

Meetings will generally be held monthly, as driven by the need to meet key milestones. Meetings will be approximately 1 hour online.

The HCF Programme Team

The SRO has delegated day-to-day management of the HCF Programme (and programme team) to the Chief Advisor, DSS. The programme team is responsible for carrying out the day-to-day programme management activities.

Key Roles and Responsibilities

In addition to the governance groups outlined in the sections above, several individuals have programme roles and responsibilities, as outlined in **Table 56** below.

³⁰ Prior to transferring the project to MSD, the governance groups included Whaikaha representatives. Many of these representatives have either transferred to equivalent roles in MSD or have been replaced by the relevant MSD representative.

Table 56: Key Roles and Responsibilities

Role	Description and Responsibilities
Senior Responsible Owner (SRO)	The Programme SRO – the Associate Deputy Chief Executive DSS – is Chair of the JAGG and holds overall responsibility for the programme on behalf of MSD. This includes overall accountability for ensuring the programme is delivered to schedule, and meets its objectives and desired outcome within the budget. The SRO reports directly to the Chief Executive and chairs the Steering Group.
Chief Clinical Advisor, DSS	A key programme SME who provides endorsement of key programme deliverables, including this PBC.
Programme Director, Crown Infrastructure Delivery Limited	Provides infrastructure delivery expertise and supports the SRO with leadership of the JAGG, development of business cases, and DBCs, and the delivery of infrastructure projects.
HCF Working Groups	HCF working groups will be used as a stakeholder engagement forum and will be kept informed throughout the programme as required.

Health New Zealand Planning

Health New Zealand has a master plan for upgrading its facilities. The RIDSS Detailed Business Case will actively integrate and align with this plan, and ensure consistency with the latest HCF thinking. It will be further considered in light of Health New Zealand's clinical service planning, which would see the move to a consolidated three-site model. This alignment will be supported through clear oversight and direction from the Joint Agency Governance Group (JAGG).

6.3 Programme Management Strategy and Framework

6.3.1 Programme and Project Methodology and Ownership

Crown Infrastructure Delivery Limited is MSD's partner for RIDSAS delivery in the HCF Programme. CID has experience supporting the delivery of infrastructure projects for government agencies without core capital delivery capability and experience integrating with project teams that have limited internal capability to manage risk, finances, and reporting. CID has been leading the update of the Programme Business Case following Gate 0 review and will continue to lead future DBCs for RIDSAS and future phases. Development of business cases and delivery for RIDSS tranches may be led by Health New Zealand, with exact roles to be determined as future DBCs are developed.

This section reflects CID's best practice in programme management. CID uses 'Managing Successful Programmes' as our Programme Delivery framework. The Managing Successful Programmes approach is a best-practice framework for managing complex, transformational change by co-ordinating multiple related projects under one strategic vision. It helps organisations achieve strategic objectives by ensuring strong governance, clear benefits realisation, and effective stakeholder engagement.

CID uses Prince 2 for its Project Delivery Framework. Prince 2 is a well-established structured project management approach that emphasises clear roles, defined processes, and a strong focus on business justification. It provides a scalable, process-driven approach that ensures projects are delivered on time, within scope, and aligned with organisational objectives.

These approaches will be embedded in the Programme Management Plan that CID develops for this work as part of future DBCs.

The RIDSS components of this programme (tranches two and five) will be managed by Health New Zealand using their project management methodology, which will be outlined in the relevant DBCs.

6.3.2 Programme Management

The programme methodology outlined in this section reflects MSD-DSS organisational practices and CID best practice for governing infrastructure investments.

Under their SA with CID, MSD as the lead agency will be accountable for the project across the investment lifecycle, and CID will be accountable to MSD for delivering the project.

CID will use the standard Service and Delivery Agreements that they have developed and agreed with other Crown entities as the basis for any agreements between CID and MSD. The roles and responsibilities of key parties in those agreements (e.g., during the investment's planning and delivery) are outlined in summary form in Annex 1 of Treasury Circular 2025/11: The Crown Infrastructure Delivery Limited Mandate.

Governance and funding roles and responsibilities span both the planning and delivery phase of the investment lifecycle as outlined in Annex 2 of Treasury Circular 2025/11: The Crown Infrastructure Delivery Limited Mandate.³¹

6.4 Interdependencies with non-build workstreams

This PBC seeks investment for the upgrade and renewal of HCF infrastructure, a key part of the Operational Strategy in the 'Environments and Infrastructure' domain. Other workstreams in the Operational Strategy include:

- Workforce
- Policy and Operations
- Funding and Commissioning

MSD-DSS is aware that there are interdependencies with each workstream and is working constructively with Health New Zealand and the Ministry of Health to address some of the key non-build aspects of the HCF.

Examples of priority engagement include:

- Concurrent to the development of this PBC, DSS is working with the Ministry of Health on responding to the system 'blocker' identified by the Gate 0 review to clarify roles and responsibilities and to strengthen overall operational governance arrangements to monitor and respond to trends and collective issues across the HCF.
- DSS is working with Health New Zealand on an Operating Model for RIDSS, setting out patient flows through RIDSS hospital beds, including regional and national relationships, roles and responsibilities for risk (clinical, etc.), key decision-making points and escalation pathways.

Future DBCs will provide further detail on how broader HCF work has an impact on the proposed investments in each tranche.

6.5 Stakeholder Engagement and Communication

MSD-DSS have developed a draft Communications and Stakeholder Engagement Strategy to detail the initial approach for communications across both internal and external stakeholders. This has been reviewed by CID to ensure it reflects best practice for engagement around infrastructure delivery. This is a live document and will be continuously updated as the programme progresses.

The early drafting of this strategy reflects the importance of early engagement with other government agencies due to joint-agency responsibility for the HCF and the need to engage with potential delivery partner/s ahead of subsequent DBCs.

The draft Stakeholder Engagement and Communications Strategy objectives are to:

³¹ [Treasury Circular 2025/11: The Crown Infrastructure Delivery Limited Mandate | The Treasury New Zealand](#)

- Clearly define the roles and responsibilities of the agencies, funders, and providers involved in the delivery of HCF supports.
- Maintain cross-agency organisational alignment and necessary statutory and non-statutory interfaces to support delivery of the assets for expanded capacity in the HCF network.
- Inform providers of their ongoing role in providing RIDSAS services and gain their continued insights into what is needed to make delivery of HCF supports sustainable for clients.

Key programme stakeholders have been named and categorised according to the categories outlined in the tables below.

Table 57: Engagement Categories

Level	Category	Description
Level 1	Engage	• Will be significantly impacted by the project and/or will have direct involvement and contribute to the project • Some stakeholders in this category will have a lot of influence and are likely to be decision makers.
Level 2	Consult	• Will be operationally impacted by the project and will have the ability to influence the development process.
Level 3	Inform	• Update requiring stakeholders • Not necessarily affected but have an interest in the project or aspects of it

A summary of how the internal and external stakeholders have been categorised into engage, consult, and inform is provided in the table below. These categories are likely to evolve as the programme progresses.

Table 58: Categorisation of Internal and External Stakeholders

Level	Category	Internal Stakeholders	External Stakeholders
Level 1	Engage	• HCF Project Team (inc. CID staff) • GM Design, Delivery and Data • Programme SRO • Environments and Infrastructure Working Group • Policy and Operations Working Group • Funding and Commissioning Working Group • Workforce Working Group • Programme Steering Group • JAGG • Minister for Disability Issues	• MoH • Health New Zealand (RIDSS) • Kāinga Ora • Te Waihanga • Treasury
Level 2	Consult	• Relationship and Contract Managers • Wider DSS – Finance, Legal, Commissioning	• Oranga Tamariki • NGO Providers (RIDSAS) • Needs Assessment and Service Co-ordination (NASC) • WDistrict Inspectors • Care co-ordinators • Care Managers • Specialist Assessors • Whaikaha – Ministry of Disabled People
Level 3	Inform		• RIDSS and RIDSAS facility staff • Corrections • Ministry of Justice • Police • MBIE • Office of the Ombudsman



- Care Recipients
- Care Recipient whānau
- General Public
- Public Service Commission

Refer to the draft Communications and Stakeholder Engagement Strategy in **Appendix AA** for the full mapping of internal and external stakeholders and an initial engagement and communications approach outlined for each stakeholder.

As part of the response to the Gate 0 review (see **section 6.11** below), a specific Ministerial Engagement Plan (included in the Communications and Stakeholder Engagement Strategy at **Appendix AA**) has been developed, to ensure that the various Ministers with responsibility for different aspects of the HCF framework are kept informed about the development of the PBC and subsequent DBCs, and the wider HCF work programme.

6.5.1 Engagement with Partner Agencies

The Programme Director is responsible for updating the Communications and Engagement Strategy to reflect updates to the partnering environment, with the SRO holding overall responsibility for the partnering strategy.

MSD has engaged with Health New Zealand, Kāinga Ora, and the Department of Corrections as part of this PBC. This engagement is ongoing and will provide input to align system thinking and subsequent business cases that seek capital funding.

6.6 Programme Plan

As the preferred RIDSAS delivery partner, CID will lead the development of a detailed programme plan during the DBC stage. The PMP will also record the suitable delivery partners for other services once agreed. The Programme plan will reflect the programme management arrangements agreed between MSD and CID and any other partner agencies.

The PMP will consider engineer, principal, and design requirements, dependencies and risks, and monitoring and control requirements, as well as detailing any operational impacts and transition requirements for the refurbishment and replacement of existing RIDSS and RIDSAS facilities.

As the Preferred Option identified in the Economic Case, the programme tranches for Option 4: Care Continuum through New Build are provided in Figure 26, with a high-level overview of key programme milestones provided in **Table 59**.

The delivery of RIDSAS and RIDSS capacity has been organised into separate tranches to simplify the delivery approach. This reflects the differences between RIDSAS and RIDSS facilities with different operators (NGO providers for RIDSAS compared to Health New Zealand for RIDSS) and the potential for different delivery partner/s and ownership structures.

Following the delivery of each identified programme tranche, there will be off-ramp opportunities. However, if the proposed investment detailed in this PBC is not delivered in full, it will prevent full achievement of the identified programme benefits.

If the Programme is not delivered or an off-ramp is selected following partial programme delivery, the only remaining option is to rely on the Interim Relief Process. This process provides limited funding to address identified HCF issues, such as fixing a door or fence to meet the Secure Services Matrix. These requests for urgent funding are not designed to provide the programme investment required to address the Problem Statements outlined in the Strategic Case. The Interim Relief Process is not an adequate response to increasing system capacity and addressing quality issues.

Table 59: Key Programme Milestones

Key Programme Milestones: Tranche One	
Indicative Key Milestones	Estimated Timing
PBC Ministerial and Cabinet Approval	May 2026
Tranche One DBC Procurement	June 2026
Tranche One DBC Development	June 2026 – November 2026
DBC MSD Chief Executive Approval	November 2026
DBC Gateway Outcome	December 2027
DBC Ministerial Approval	February 2027
s9(2)(f)(iv)	
Tranche One Contractor Procurement	June/July 2027
Tranche One Design Commences	September 2027
Tranche One Construction Commences	March 2028
Tranche One Construction Completed	June 2030

6.6.1 Why is a RIDSAS business case the appropriate next step?

A DBC for the delivery of RIDSAS capacity is the appropriate next step for the programme, following the approval of this PBC to address critical capacity and quality requirements across key regions.

In the Northern region, there is a critical need to deliver new RIDSAS capacity and address quality issues with the existing s9(2)(c) RIDSAS facility to improve the efficiency of the existing RIDSS, as existing RIDSS clients will be able to transition through the care continuum. This will ease pressure on the existing RIDSS facility, which is already at capacity and limiting the ability for clients to flow through the system.

In the Central region, two new RIDSAS facilities are required to match the existing and sufficient RIDSS capacity to support clients to flow through the care continuum and prevent system blockages where clients are held in secure care for longer than they require because of capacity limitations.

Midlands and Southern RIDSAS facilities do not receive investment through Tranche One because they are not a relative priority. In the Midlands, the required capacity can be temporarily met through the new Northern RIDSAS facilities and in the Southern region, there is sufficient interim capacity (despite ongoing quality concerns).

The delivery of new and refurbished RIDSAS capacity in the first tranche allows for design and construction efficiencies to be sought across the North Island. It also allows for the programme to apply any learnings gained from Tranche One to later RIDSAS tranches.

6.6.2 Programme Tranches

Figure 26: Programme Plan by Tranche

Interventions	Design Start	Construction Start	Construction End	Capital Funding Requirement – Nominal (\$m)	FY27				FY28				FY29				FY30				FY31				FY32				FY33				FY34				FY35				FY36				Post FY36
					1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4									
Tranche 1: RIDSAS Only	October 2027	April 2028	September 2030	30.89																																									
Refurbish Northern s9(2)(c) RIDSAS [5 RIDSAS]	October 2027	April 2028	March 2029	5.83																																									
New Northern RIDSAS [5 RIDSAS]	March 2028	September 2028	September 2029	8.42																																									
New Central RIDSAS [5 RIDSAS]	October 2028	March 2029	March 2030	8.32																																									
New Central RIDSAS [5 RIDSAS]	April 2029	October 2029	September 2030	8.32																																									
Tranche 2: RIDSS Only	March 2030	December 2031	November 2033	33.42																																									
New Northern RIDSS [2 Assessment, 10 Secure]	March 2030	December 2031	December 2032	27.75																																									
New Northern Stepdown [4 Stepdown]	December 2031	August 2032	December 2033	5.67																																									
Tranche 3: RIDSAS Only	January 2032	June 2032	June 2034	25.03																																									
New Midlands RIDSAS (Walsh Replacement) [5 RIDSAS]	January 2032	July 2032	June 2033	9.67																																									
Refurbish s9(2)(c) RIDSAS [5 RIDSAS]	January 2033	June 2033	November 2033	7.66																																									
New Southern RIDSAS s9(2)(c) [4 RIDSAS]	July 2032	May 2033	June 2034	7.69																																									
Tranche 4: RIDSAS Only	January 2034	July 2034	June 2036	12.65																																									
New Southern RIDSAS s9(2)(c) [4 RIDSAS]	January 2034	July 2034	June 2035	9.39																																									
Refurbish Southern s9(2)(c) RIDSAS [6 RIDSAS]	January 2035	July 2035	June 2036	3.25																																									
Tranche 5: RIDSS Only	January 2036	July 2036	Post July 2036	71.21																																									
New Christchurch Stepdown [4 Stepdown]	January 2036	July 2036	June 2037	6.61																																									
Refurbish Dunedin Stepdown [4 Stepdown]	Post July 2036			4.58																																									
New Southern RIDSS [2 Assessment, 8 Secure]	Post July 2036			30.01																																									
New Midlands RIDSS including Stepdown [2 Assessment, 6 Secure, 2 Stepdown]	Post July 2036			30.01																																									

6.7 Change Management

Since signing in a Services Agreement in October, MSD and CID have begun integrating and allocating appropriate change management responsibilities for infrastructure delivery. CID's Change Management approach will draw upon its infrastructure delivery experience and reflect the organisation's best practice, and will be outlined in detail in subsequent DBCs. Any changes that may need to occur to service delivery will be managed by MSD under its change management framework.

MSD's Integrated Change Portfolio (ICP) represents MSD's approach to change management. It forms a boundary to present what MSD defines as change, to better enable enterprise governance to proactively support delivery of health and make investment decisions, balancing demands and constraints across the whole. The Integrated Change Portfolio is a foundational enabler that can be built on to provide richer information, insight and value for decision makers.

As the programme progresses, a detailed Change Management Plan (CMP) will be drafted by MSD-DSS and CID, with change requests being escalated to the appropriate governance forum as they arise during programme delivery for review and approval. This CMP will identify, assess and manage the business changes required to achieve the HCF Programme Investment Objectives and realise the anticipated benefits.

The CMP will include the following sections:

- **Change Objectives:** description of the programme change objectives to guide development of the CMP.
- **Preparing for Change:** description of the existing people, organisations, and/or policies that are likely to be impacted by the programme and describe how the programme is preparing for the change.
- **Change Impacts:** description of the people and services impacted by the change, what is being changed, the timeframe for the change and the related objectives of the change.
- **Change Leadership and Governance:** description of the change roles and related responsibilities.
- **Change Principles:** description of the agreed principles to deliver the change, e.g. regular communication to impacted stakeholders.
- **Change Impact Assessment:** table outlining the person/organisation/area impacted, how they are impacted, mitigations, responsibility, timeframes, and the change impact (small, medium, or large).
- **Managing Change:** description of the activities required to support change management, such as stakeholder engagement and communication, project reporting, and long-term investment and operational planning.

The HCF Programme's change management objectives are to:

- Minimise the negative impacts of the change on HCF clients, care recipient whānau, and staff
- Engage and communicate with potential delivery partners early and in a clear, concise, and targeted manner
- Engage and communicate with impacted stakeholders such as clients, whānau, providers, and staff as early as possible to elicit feedback and communicate change impacts
- Ensure visibility of the change management process is provided to the Steering Group, JAGG, MSD leadership, and partner agency leadership (as applicable)
- Ensure change related risks are regularly reviewed and reported to programme governance.

Key change areas include:

- **RIDSS and RIDSAS facility operations:** the delivery of new and refurbished facilities will result in changes to people (staff and clients), processes and technology.

- **RIDSS and RIDSAS facility construction:** the refurbishment and construction of new facilities will result in construction change impacts, such as disruption to neighbours and the need to transition clients to carry out refurbishments.

Table 60 provides an overview of the HCF Programme change owners. As the programme progresses and delivery partners are appointed, additional change owners may be required. The CMP will evolve to reflect the policies, procedures and responsibilities of partnering agencies.

Table 60: Change Management Roles and Responsibilities

Change Responsibility	
Role	Responsibility
Programme SRO	Overall responsibility for the HCF Programme, including change management.
JAGG	Reviews and endorses HCF programme deliverables including the CMP.
Change Manager	Develops and updates the benefits profile and mapping. Responsible for development of the CMP to ensure all business units and stakeholders are prepared for the change.
HCF Programme Manager	Supports the change manager to develop benefits and change management documentation.
Project Team	Supports the change manager to develop benefits and change management documentation. Carries out day-to-day change management activities.

6.8 Benefits Realisation Management

Benefits realisation management is the approach or process to producing and demonstrating tangible results that can be reasonably attributed to the activities and initiatives undertaken through projects, programmes, and portfolios. The Benefits Realisation Strategy will quantify the benefits using factors/ measures attributed to the Projects while attempting to optimise the realisation of benefits.

Once the programme has been endorsed, a more detailed Benefits Realisation Plan (BRP) will be developed detailing how each project, and the HCF programme, will deliver its intended outcomes and realise the identified benefits. The BRP will be continuously updated as the programme progresses through the approvals process.

The HCF Programme benefits management approach will align to Treasury guidance. Benefits will be:

- **Identified:** The HCF Programme benefits have been identified as well as a series of associated KPIs and measures.
- **Analysed:** Following approval of the PBC, the benefits will continue to be quantified, compared and assessed.
- **Planned for:** Following approval of the PBC, the BRP will be developed to outline how the benefits will be realised, by whom and by when.
- **Realised, monitored and reported:** The programme will report on benefits realisation and the risks to the benefits not being realised.

For each of the benefits identified in the ILM and outlined in Figure 28, detailed benefits profiles will be developed according to the structure in **Table 61**.

Table 61: Benefits Profile Structure

Benefits Profile	
KPI	KPI Description
Measure	Measure Description
	Baseline value and date
	Target value and date
	Interim target value and date
	Data source used to measure the KPI
Reporting	Forum where KPI will be reported
	Date reporting will start
	Frequency of reporting
	Date reporting will end
Responsibility for Reporting	Name
	Position
	Organisation

An overview of the planned benefits, roles and responsibilities is provided in **Table 62**. These roles and responsibilities will be reviewed and updated when agency delivery partner/s are confirmed.

Table 62: Benefits Roles and Responsibilities

Benefits Roles and Responsibilities	
Role	Responsibility
SRO	Accountable for realisation of the HCF Programme benefits.
Benefits Owner(s)	Authorise the development of the benefit profiles and own the performance drivers that influence achievement of a benefit. Ensure the benefits measurement and reporting occurs regularly and is embedded in the organisation.
Change Manager	Responsible for delivery of the Benefits Management Plan and Benefits Realisation Plan. Responsible for stakeholder engagement and communication required to achieve the stated benefits.
Benefits Manager	Responsible for updating the Benefits Management Plan and Benefits Realisation Plan.
Project Team	Responsible for developing the Benefits Management Plan and Benefits Realisation Plan in collaboration with the Benefits and Change Managers.

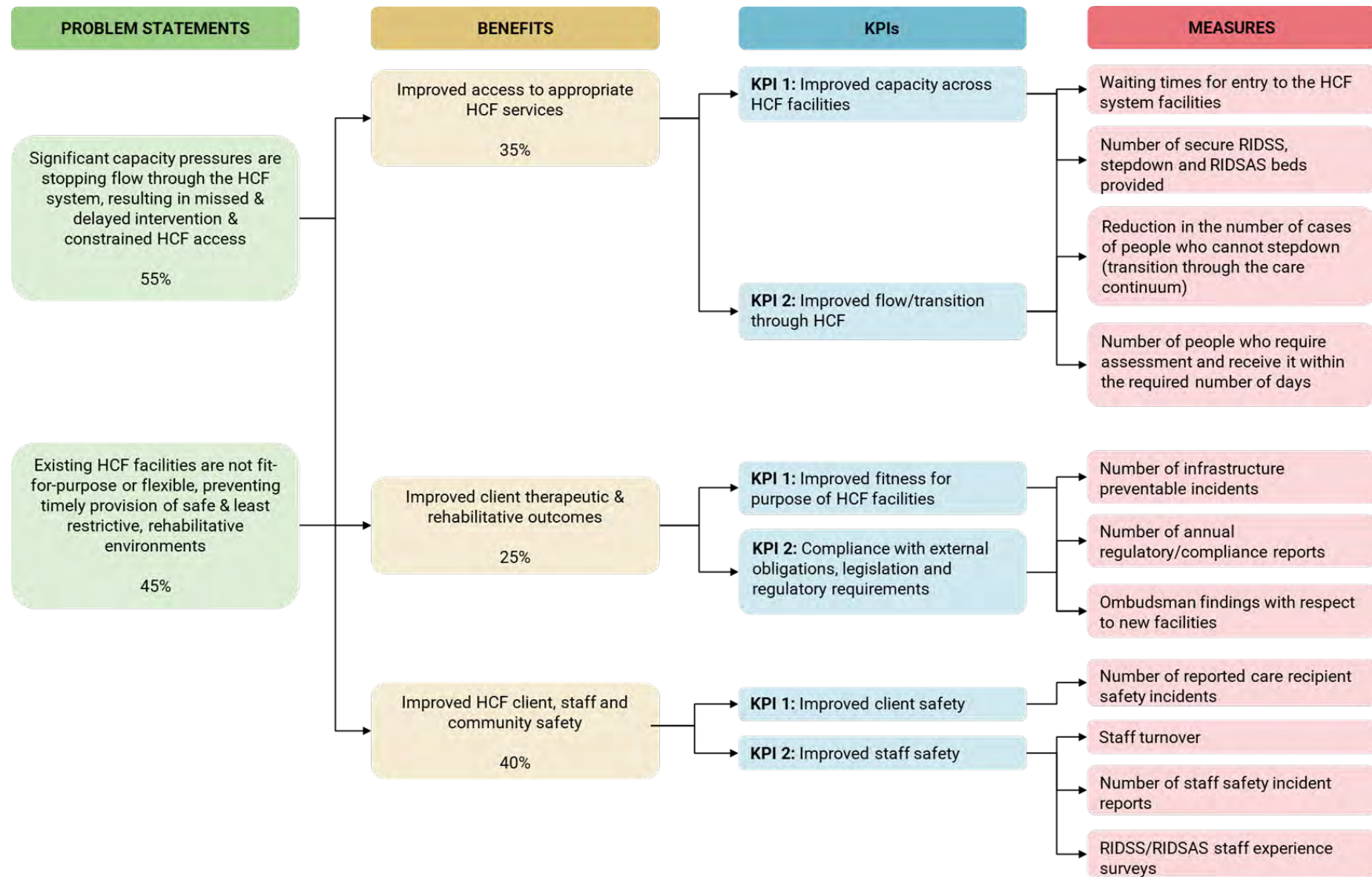
An overview of the planned benefits reporting arrangements is provided in **Table 63**. These roles and responsibilities will be reviewed and updated when agency delivery partner/s are confirmed.

Table 63: Planned Benefits Reporting Arrangements

Benefits Reporting	
Report	Description
Benefits Realisation Report	A regular report provided to programme governance to outline the actual benefits achieved by the HCF Programme and the actions required to achieve the benefits.
Treasury reporting	As agreed with Treasury.
Cabinet Reporting	Report to Cabinet outlining the actual benefits achieved compared with the benefits outlined in this PBC.

Figure 27 provides an overview of the key programme benefits and their related KPIs and measures. These benefits have been linked to the Strategic Objectives and Investment Objectives, as outlined in the Strategic Case.

Figure 27: Initial Benefits Realisation Plan (BRP) for the HCF Programme

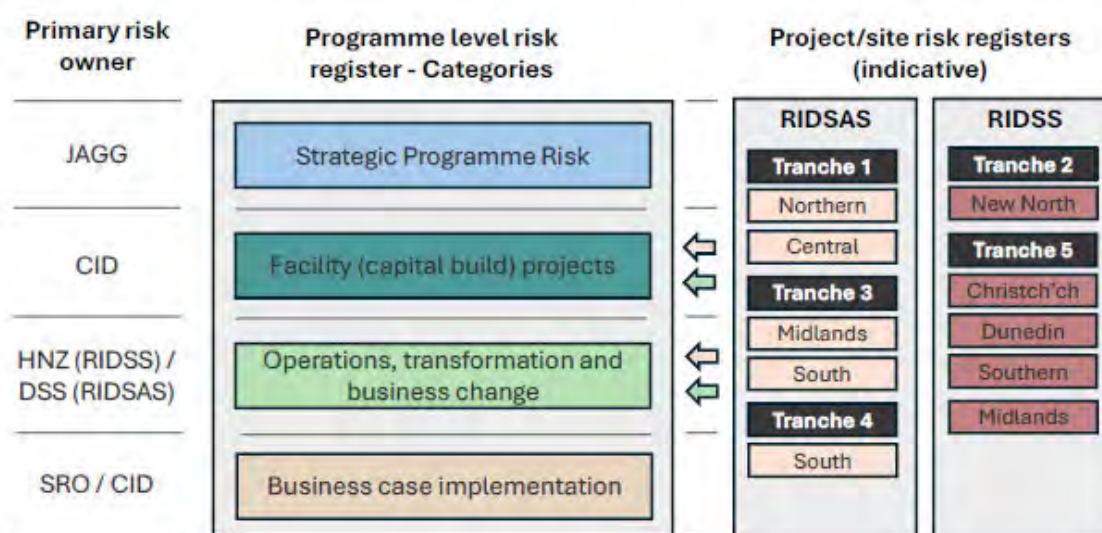


6.9 Risk Management

Risk Management for the HCF is complex and sits across multiple agencies. In February 2026, the JAGG approved a four-tiered approach to risk developed by CID. This structure (outlined in **Figure 28**) disaggregates risk into four categories, each with its own risk register:

1. **Strategic Programme Risk:** This covers the whole of programme risks that cut across agencies and workstreams, including key dependencies and assumptions that underpin benefits realisation and sequencing.
2. **Facilities (build) Projects:** This focuses upon risks inherent to capital delivery, in line with Gate 0 recommendations (see **section 6.11**), including scope, cost, schedule, site conditions, procurement strategy, market capacity, and delivery interfaces across sites and tranches. This risk register
3. **Operations, transformation and business change:** This captures non-build operational risks, including workforce readiness, operational transition, and supporting policy or commissioning changes. Risk registers can be developed at the site level and rolled up into a programme-level register.
4. **Business case implementation:** This addresses risks from progressing from the PBC into a pipeline of DBCs, including information maturity, assurance, approvals, governance decisions and consistency across tranches.

Figure 28: Disaggregation of HCF Programme Risk



6.9.1 Organisational Risk Culture

At a strategic level, the HCF Programme will adopt a Risk Management Strategy and Framework that is consistent with existing CID, MSD, and HNZ risk management policies, including the MSD risk culture, risk essentials, risk ownership and risk rating guidance, as well as the overarching MSD Risk Management Plan.

The HCF Programme will align with the MSD risk principles, which are:

- Be comfortable talking about risks
- Be familiar with and apply the MSD risk framework
- Escalate and discuss risks with the areas that could be impacted
- Integrate risk management into daily decisions and actions
- Controls are built in by design
- Take personal responsibility to manage risks

The HCF Programme will foster a positive risk culture through the areas of MSD risk culture outlined in **Table 64**.

Table 64: MSD Risk Culture Areas

MSD Risk Culture	
Area	Description
Systems and Processes	We support innovation to improve the accessibility, availability, and useability of our systems, processes, and practice. We build controls into our systems and processes by design to ensure the security and quality of all information and data including how it is used, managed, and governed.
Our Staff	Our people are at the heart of everything we do. We are dedicated to creating a workplace where everyone feels safe, valued, and supported. Guided by our principles and values, we ensure a culture where staff can safely manage risks and contribute to our long-term resilience and success.
Risk Approach	We expect the identification, monitoring and escalation of risks, issues in everything we do. We want to see controls in place to manage the risks and ensure that they are owned, managed and/or accepted at the right level, and, shared when working with others.
Delivering Services	Our performance against objectives must be measured, monitored, and proactively managed. We meet the needs of our clients, their whānau, and communities through best practice and in alignment with our policies and processes.
Business Change	We expect a collaborative, consistent, and risk-based approach to transformation and business change that has *human centred design and partnering at its core. We want to understand, and manage, any co-existence risks arising from the implementation of business change while delivering our core services.
Treaty Obligations	We expect Te Tiriti o Waitangi to be considered in the design and delivery of services. We ensure that our engagement with all stakeholders is culturally appropriate and considered.
Organisational Integrity	We are proactive in maintaining the Ministry's Integrity. Policies and controls should be accessible, monitored and managed to ensure prevention and detection and ensure compliance with regulations and legislation.
Health, Safety, Security and Wellbeing	We keep health, safety, security, and wellbeing at the forefront of every action, and prioritise our own safety and the safety of clients, partners and others affected by our work.
Fiscal Sustainability	We prioritise our expenditure and investment, to ensure it is appropriate, sustainable, and contributes to the strategic objectives of the Ministry and Government priorities.

MSD uses the Five Lines Model outlined in **Table 65** to provide structure around risk management and internal controls by defining roles and responsibilities, the relationship between them and identifying what assurance exists and how it is monitored.

Table 65: The Five Lines Model

Fine Lines Model	
Line	Description
Line 1	All staff identify and manage risks in their everyday roles.
Line 2	The business areas that set Ministry-wide expectations through policies, processes and procedures and monitor their effectiveness.
Line 3	Provide objective assurance by reviewing activities undertaken by Line 1 and Line 2 to safeguard the control environment.
Line 4	External bodies and regulators who provide us with standards and recommendations.
Line 5	Our Leadership Team who are responsible for risk management practice and our control environment.

6.9.2 Organisational Risk Management Processes

Risk identification, management and escalation for the HCF Programme will align with existing MSD risk policies. The risk management processes will be reviewed when the programme delivery partners are confirmed to ensure risks are owned by the agencies best placed to manage them.

Risks will be raised throughout the programme lifecycle, with all members of the programme, including the project team, contractors and governance, responsible for raising risks for the Programme Manager to record in the HCF Programme Risk Register (see **Table 66** for high-level risks).

Once a risk is identified, it will be analysed and scored based on the risk consequence and likelihood that the risk consequence will eventuate according to the MSD Business Risk Rating Matrix provided below in **Figure 29**. A risk rating is established for:

- Inherent Risk: level of risk before controls
- Residual Risk: current level of risk with controls in place
- Predicted Risk: estimated level of risk with planned mitigation(s) in place

Any risks that cause significant concern will be escalated by the Programme Manager to the Steering Group and/or JAGG for discussion.

Figure 29 29: MSD Business Risk Rating Matrix

Risk Likelihood	Risk Consequence				
	Routine	Minor	Moderate	Major	Severe
Almost Certain (81-100%)	Medium	Medium	High	Very High	Very High
Likely (51-80%)	Low	Medium	Medium	High	Very High
Possible (31-50%)	Low	Low	Medium	High	High
Unlikely (6-30%)	Very Low	Low	Medium	Medium	High
Rare (5% or less)	Very low	Very Low	Low	Medium	Medium

6.9.3 Programme Risk Register

A Risk Register has been developed and will be progressively updated as more detailed analysis is undertaken. As risks and issues are identified throughout the life of the programme, they will be recorded in the risk register. Risks will be assessed based on the current likelihood and consequence and the target likelihood and consequence of each risk/issue – considering the key controls in place, the effectiveness of the control(s), and any assurance activities in place to effectively mitigate the risk/issue to arrive at a final rating.

A summary of the highest rating programme risks is presented in **Table 66** below.

Table 66: Key Programme Risks

Risk	Controls and Mitigations	Post mitigation Consequence	Post-mitigation Likelihood	Post-mitigation Risk Rating
STRATEGIC RISK IF programme governance and wider government are not kept informed THEN endorsement and approvals process may be delayed WHICH may result in a lack of timely investment in HCF facilities and an adverse impact on quality of care.	- Regular engagement with programme governance (Steering Group and JAGG) - Development of Stakeholder Engagement and Communications Strategy - Development of detailed programme timeline with timelines for approvals by approving party, circulated to approvers in advance	Major	Possible	High
STRATEGIC RISK IF delivery entities and ultimate departmental responsibility for RIDSS and RIDSAS facilities cannot be determined THEN the ability to execute and manage delivery of these facilities may be compromised.	- Development of Communications and Engagement Plan with clear messages and communication channels to engage with potential partner agencies - Holding discussions early with potential partner agencies	Major	Likely	High
STRATEGIC RISK IF the ultimate responsible government entities responsible for the governance of the RIDSS and RIDSAS capital delivery programme cannot be determined THEN the next stage of this investment programme may not progress.	- Development of Communications and Engagement Plan with clear messages and communication channels to engage with potential partner agencies - Early engagement with potential partner agencies - Work with senior leaders to discuss urgency of investment	Major	Likely	High
STRATEGIC RISK IF a decision is not made about RIDSS and RIDSAS land and asset ownership (between providers, MSD, KO, Health New Zealand, MoH) THEN it may complicate the ability to land a commercial delivery structure WHICH may delay facility delivery and the realisation of benefits.	- JAGG established in April 2025 and refreshed in January 2026 to oversee the HCF joint agency work programme (which includes this HCF RIDSS and RIDSAS facility investment). - The PBC delivery options, which outline land and asset ownership options, will be presented to programme governance for review and feedback. - MSD will engage with potential delivery partners to understand the appetite and possibilities for land and asset ownership. - The programme tranches separate RIDSS and RIDSAS investment so that RIDSAS investment can proceed while decisions are made about the RIDSAS investment.	Moderate	Unlikely	Medium
BUSINESS CASE RISK IF the Crown cannot purchase existing RIDSAS facilities/land from providers THEN changes to the Preferred Option may be required to reduce the investment risk to the Crown WHICH may result in delays to the programme.	- Development of Communications and Engagement Plan with clear messages and communication channels to engage with providers - Development of a realistic preferred option with a series of new builds on new land and new builds/refurbishment on existing land which could be adapted to suit the ownership reality - Tranche One investment only includes one refurbishment with three new builds with no existing ownership discussions required. - Engage with providers early to understand ownership potential	Major	Unlikely	Medium
BUSINESS CASE RISK IF MSD cannot identify internal capability or agree a suitable delivery partner THEN the capital delivery programme could be at risk WHICH means MSD cannot provide additional capacity across the HCF and cannot meet the Ombudsman recommendations.	- Proactive engagement with other Crown agencies to identify and leverage their project delivery expertise. - Early engagement to explore options to bolster internal capability and capacity - Extensive testing in the DBC of the delivery feasibility of capital solutions	Major	Rare	Medium
BUSINESS CASE RISK IF government ownership of the RIDSAS facilities is not possible and providers are funded to provide RIDSAS facilities THEN this could create 'lock in' to those providers that own community secure facilities.	- Development of Communications and Engagement Plan with clear messages and communication channels to engage with providers - Tranche One investment only includes one refurbishment with three new builds with no existing ownership discussions required. - Engage with providers early to understand ownership potential	Moderate	Possible	Medium
OPERATIONAL RISK IF capital constraints mean only the first Tranche of planned RIDSAS investment proceeds THEN the HCF may continue to experience operational pressure WHICH may result in the inability for people to enter the HCF and transition from secure to community environments.	- Early engagement with Treasury and communication with Ministers to discuss importance of the programme. - Regular engagement with programme governance to make the programme a continuous MSD and sector priority and emphasise the consequences of not investing in the programme for care recipient, whānau, and staff. - Development of Communications and Engagement Plan - Continue to emphasise the importance of investment in HCF facilities to comply with regulatory requirements to key stakeholders.	Major	Unlikely	Medium
BUSINESS CASE RISK IF the programme does not receive funding from Cabinet THEN RIDSS and RIDSAS capacity and quality issues will persist WHICH could contribute to regulatory breaches.	- Early engagement with Treasury and communication with Ministers to discuss importance of the programme. - Regular engagement with programme governance to make the programme a continuous MSD and sector priority and emphasise the consequences of not investing in the programme for care recipient, whānau, and staff. - Development of Communications and Engagement Plan - Continue to emphasise the importance of investment in HCF facilities to comply with regulatory requirements to key stakeholders.	Major	Unlikely	Medium

Risk	Controls and Mitigations		Post mitigation Consequence	Post-mitigation Likelihood	Post-mitigation Risk Rating
OPERATIONAL RISK IF there refurbished and/or new HCF facilities cannot be staffed due to ongoing workforce constraints THEN it may result in delays to opening new facilities WHICH may delay achievement of the programme benefits.	- Tranche One investment is based in the Northern (Auckland) and Central (Wellington) regions with access to populated cities with a larger workforce. - Even through the Preferred Option is based on a decentralised delivery model, many facilities are based in semi-rural areas near to populated cities such as Auckland, Hamilton, Wellington, Christchurch and Dunedin with access to large workforces. - Engage with providers to understand workforce constraints and develop a plan to recruit and/or train the workforce required to staff new facilities.		Moderate	Possible	Medium
FACILITY CAPITAL BUILD RISK IF site-specific constraints (including planning, consenting, utility connections, geotechnical conditions, and design standards for secure facilities) are more complex than assumed at the Programme Business Case stage THEN design development and consenting timeframes may be longer than anticipated WHICH could result in construction delays, increased costs, and impacts to the delivery of planned tranches.	- Progressive design development through the DBC to confirm site feasibility and consenting pathways - Early engagement with local authorities and key technical advisors - Use of standardised design principles where appropriate to reduce variability		Moderate	Possible	Medium
FACILITY CAPITAL BUILD RISK IF construction market capacity constraints, labour shortages, supply or cost escalation persist or worsen during the delivery phase THEN procurement outcomes, programme sequencing, and construction costs may be adversely affected WHICH could require reprioritisation of tranches, scope adjustments, or additional funding.	- Tranche-based delivery to manage exposure to market conditions - Early market sounding and procurement strategy development at DBC stage - Allowance for contingency and escalation within investment assumptions		Moderate	Possible	Medium

6.10 Programme Reporting and Business Assurance Arrangements

This investment proposal has been assessed as high risk using the Treasury's Risk Profile Assessment tool and moderation process. The proposal is subject to on-going Gateway reviews. A Gate 0 review has been carried out on this programme. This business case reflects the review team's advice and feedback.

A Programme Assurance Plan will be developed for each DBC, and set out how internal controls, oversight and independent external reviews will provide progressive confidence that the programme remains on track to deliver its intended benefits, within agreed scope, time and budget. It will describe the key assurance products (including internal quality reviews, programme health checks, Gateway and other independent reviews), how these align with critical decision points, and how findings will be reported to and acted on by the JAGG. The Plan will be reviewed and updated regularly as the programme matures, with particular focus on high-risk phases such as procurement, contract award, and transition to operations.

Assurance activity will be risk-based and coordinated through the Programme Director, under the direction of the Senior Responsible Owner and programme governance. The Programme Assurance Plan will define roles and responsibilities for commissioning and overseeing assurance, the schedule of assurance activities and gateways, and the expected audiences for each review (for example, JAGG, DSS and MoH agency executives). It will also describe the arrangements for tracking and closing actions arising from assurance reviews, and how assurance insights will be integrated into programme reporting, risk management and benefits realisation planning. This will ensure that decision-makers receive timely, evidence-based assurance on programme status and residual risk as they consider key approvals throughout delivery.

6.10.1 Programme Reporting Requirements

The HCF Programme reporting requirements are outlined in **Table 67**.

Table 67: Programme Reporting Arrangements

Programme Reporting Requirements	
Reporting Types	Expectations
Project Status Reporting	Monthly status reports to show whether the project is on track or at risk.
JAGG Summary Report	A summary report must be prepared following the meeting which summarises the discussion, actions and any recommendations for the agencies involved. The summary report must be shared with attendees in a timely way (within a week of the meeting). All agencies will continue to report individually to their Executive Teams and Chief Executives.
Documents for Formal Endorsement / Approval	All documents required for endorsement/approval will be provided to governance in advance of meeting times.

As part of delivery planning for future DBCs, CID will review its reporting requirements and adapt them if necessary. This could include implementing project health checks for individual tranches. These are independent reviews to assess whether the project is on track in terms of governance, scope, schedule, and risk management. These checks provide early warnings and recommendations to improve delivery success.

Business Assurance Arrangement

Given the programme's high risk rating, assurance activity will be explicitly risk-based and proportionate to each Tranche/ DBC. The Programme Business Case commits to the development of a detailed Programme

Assurance Plan prior to the Detailed Business Case phase, including confirmation of Gateway and other independent review requirements, and alignment with assurance framework and Treasury expectations. This will ensure that the intensity and frequency of assurance keep pace with the evolving risk profile of the programme.

It is anticipated that key assurance activities will include: independent review of subsequent business cases and procurement strategies; targeted technical, costing and risk peer reviews for major tranches; and formal health checks or Gateway-style reviews at critical decision points (such as prior to capital commitments). These arrangements will be refined in consultation with central agencies and the JAGG, and will be reflected in the future Management Cases for subsequent business cases, including a more detailed integrated assurance schedule.

6.11 Response to Gate 0 review

In September 2025, the Treasury gave the HCF programme proposal an **AMBER/RED** rating, signalling that successful delivery of the proposed investment is 'in doubt, with major risks or issues apparent in a number of key areas.'

The gateway team noted the high quality of most of the draft PBC, though provided recommendations for strengthening each case, as well as more general recommendations relating to the programme proposal. These recommendations, and how they have been met, are outlined below.

6.11.1 Reviewing the Programme Business Case

The gateway team reviewed and assessed the Programme Business Case using the Quality Measure Score system (see **Table 68**).

Table 68: Summary of the Quality Measure Score System

Summary of the Quality Measure Score System	
Score	High-level performance standard
4	The evidence provided by the agency reflects best practice for the relevant business case stage and would highly likely result in a successful investment.
3	The evidence provided by the agency reflects an acceptable quality for the relevant business case stage and would likely result in a successful investment.
2	The evidence provided by the agency includes material issues for the relevant business case stage and may not result in a successful investment without remedial actions or wrap-around support.
1	The evidence provided by the agency is of serious concern for the relevant business case stage and there is no confidence that it will result in a successful investment.

The bulk of the PBC was assessed as acceptable quality for the relevant business case stage, except for the Management Case. Scoring for the draft PBC is shown in **Table 69**.

Table 69: Gate 0 Review of the HCF Programme Business Case

Result of Gate 0 Review of Programme Business Case	
Case	Quality Measure Score (1-4)
Strategic	3.5
Economic	3

Commercial	3
Financial	3
Management	2

Since the Gate 0 review CID has reviewed and updated the PBC to reflect:

- Gateway review feedback.
- CID's best practices in infrastructure investment delivery.

6.11.2 Addressing the Gate 0 Recommendations

The Gateway team made 6 recommendations to MSD-DSS on the HCF programme. CID's engagement meets meet several of these recommendations directly and CID is working closely with MSD-DSS on the development of plans to ensure the others are met. **Table 70** outlines the recommendations and how they are being met.

Table 70: Responses to Gate 0 Recommendations

Responses to Gate 0 Recommendations		
Gateway team recommendation (including timescale for implementation)	Priority for implementation	Action plan
R1. That the SRO develop a comprehensive Ministerial engagement plan to keep key Ministers briefed on the criticality and progress of this work.	DO NOW	A Ministerial engagement plan has been developed and incorporated into the wider stakeholder engagement plan (see Appendix X). MSD has been briefing relevant Ministers on developments with the HCF since late 2025 with engagement ongoing through the Ministerial Disability Leadership Group convened by the Ministry for Disability.
R2. That the SRO review the make-up of the governance groups to ensure that they are fit for purpose for delivery, including mitigating the risks of the complex agency arrangements, lack of capital build expertise in MSD-DSS and over-reliance on key personnel.	DO NOW	Engaged CID for programme and governance support, including senior-level representation on the refreshed governance group. Making arrangements to set up the refreshed governance group and cross-agency working group, with the support of CID Programme Director since onboarded in the week starting 3 November. The refreshed JAGG has adopted new terms of reference and has been meeting monthly since January 2026.
R3. That the SRO ensure client cohort profiles are modelled out	DO NOW	MSD-DSS and HNZ have agreed that these profiles will be fully

for a 20-year view and reviewed regularly.		addressed at future Detailed Business Case stage where: • Cohort profiles can be developed at a site- and service-specific level; • Assumptions can be tested against confirmed models of care and operational standards; • Demand modelling can be directly linked to asset typologies; • Profiles can be embedded into a living planning framework and refreshed as part of ongoing programme assurance.
R4. That the SRO review and update national standards for models of care and infrastructure relevant to the RIDs and RIDSAS services.	DO NOW	The JAGG has reviewed this recommendation and concluded that this work extends beyond the scope of this PBC and cannot be resolved in a way that is sufficiently robust or durable at the PBC stage. Therefore, work to support future DBCs will address this by: • Translating agreed models of care into clear, standardised service requirements; • Define the implications for facility typologies, capacity, and security; • Directly link standards to investment decisions, delivery sequencing and operating costs. This approach will ensure that national standards for models of care are developed with the right level of evidence, clinical input, and system alignment, and are embedded into the investment programme.
R5. That the SRO develop and implement a facilities-specific capital programme Risk Management Plan for the PBC and subsequent DBCs	DO NOW	CID has undertaken a comprehensive review of the programme's risk approach as part of finalising the PBC, and developed a Risk Management Plan for the infrastructure programme. The Plan covers (i) definition of strategic priorities for

		the investment during delivery and in operation, (ii) definition of delivery/operating risk appetites, establishment of risk context, development of risk register, confirmation of ongoing risk management approach (e.g. risk ratings, quantification of risk, risk ownership, mitigation activities, reporting, approach to emerging risk).
R6. That the SRO appoint a suitably qualified and experienced Programme/Project Director to support the SRO during the next phases of the Programme including the finalisation of DBCs and the delivery into service of the facilities.	DO NOW	In November 2025 MSD-DSS engaged CID who have provided an experienced a Programme Director to lead the development of the PBC, with the option to extend their services once decisions from Ministers and Cabinet are made.

6.11.3 Addressing the Gate 0 System 'Blocker'

The Gateway review team identified one critical 'blocker' to the successful delivery of the HCF programme proposal (see **Table 71**). The team defines a blocker as 'a critical, high-impact issue that is outside the Programme/Project's ability to control that will severely impact time, cost, quality and scope.

Table 71: System 'Blockers' for the HCF Programme

Summary of System 'Blockers' for the HCF Programme.		
Blocker	Describe specific nature of blocker	Consequence to investment if not resolved
Split responsibilities across agencies	The split roles and responsibilities between: - Ministry of Health as Regulator/ responsible for administering the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (IDCCR Act); - Health NZ as provider of RIDSS/Forensic Secure Hospital – level beds for Intellectually Disabled People; and - MSD-DSS as purchaser and commissioning and contract management agent for DSS services. The above factors result in unclear and unsustainable accountabilities.	If the lack of end-to-end accountability for flow through the system and governance arrangements for HCF are not resolved at CE and Ministerial level, then the programme benefits will not be realised and the investment would result in the current bed blocking and continuum of care flow problems remaining, but in new facilities.

In response to this 'blocker' MSD-DSS and CID have undertaken the following:

- Review and refresh of the JAGG to ensure all accountabilities are covered – updated JAGG has been functioning since December 2025.
- Developing a ministerial engagement plan to brief and get buy-in from relevant Ministers – this is included as an appendix to the Communications and Stakeholder Engagement Plan.
- Improving communication and information sharing with Health New Zealand to ensure RIDSAS and RIDSS planning is aligned – this has included a workshop between DSS and HNZ and subsequent dialogue.
- An ongoing focus for the JAGG on simplifying HCF structures wherever possible.

The Programme Director, SRO, and JAGG remain alert to the risk posed by system fragmentation and the blocker and its consequences are reviewed by JAGG at their monthly meetings.