



26 August 2021

[REDACTED]
[REDACTED]
[REDACTED]

Dear [REDACTED]

Re: OIA request – Current capacity at Auckland’s regional forensic psychiatric services (Mason Clinic)

Thank you for your Official Information Act request received on 22 July 2021 seeking information and documents from Waitematā District Health Board (DHB) relating to the capacity of the Mason Clinic.

You requested the following information:

- 1. Any reports, correspondence and other documents relating to the capacity of the Mason Clinic.**
- 2. Any reports, correspondence and other documents relating to a shortage of beds.**
- 3. Any reports, correspondence and other documents relating to any plans to increase the number of beds.**
- 4. The current capacity of beds.**
- 5. The total number of patients as at June 31 for the previous 10 years broken down by year.**

We sought clarification of your request on 29 July, where you confirmed that as part of question 1, you sought information relating to patients who were receiving inpatient care at the Mason Clinic. Further clarity was also sought for question 5, noting that the information provided would be for the previous 10 financial years, ending on 30 June 2021.

Before responding to your specific questions, it may be useful to provide some context about our services.

Waitematā is the largest and one of the most rapidly growing DHBs in the country, serving a population of around 650,000 across the North Shore, Waitakere and Rodney areas. We are the largest employer in the district, employing around 8,600 people across more than 80 locations.

In addition to providing care to our own resident population, we are the Northern Region provider of forensic mental health services and child rehabilitation services, plus the metro Auckland provider of child community dental services and community alcohol and drug services.

Waitemata District Health Board (DHB) provides forensic mental health services to residents of the Northern Region, and forensic intellectual disability services for those north of Taupo, on behalf of the other regional DHBs, at the Mason Clinic in Point Chevalier, Auckland.

In response to your request, we can provide the following information:

1. **Reports, correspondence and other documents relating to the capacity of the Mason Clinic.**
2. **Reports, correspondence and other documents relating to a shortage of beds.**
3. **Any reports, correspondence and other documents relating to any plans to increase the number of beds.**

We are providing a combined response to question 1, 2 and 3.

As noted above, the Mason Clinic provides services on behalf of the Northern Region DHBs (Northland DHB, Waitemata DHB, Auckland DHB and Counties Manukau DHB). These DHBs collectively serve a population of 1.9 million, which is projected to grow significantly in the future.

Waitematā DHB has been actively working to increase the number of beds available on the Mason Clinic site. This includes the completion of a site master plan, which details the service requirements and phasing approach to growth on the site.

We have acquired 2.8ha of land adjacent to the existing campus, to better enable redevelopment and expansion of Mason Clinic facilities. Site development will occur over a number of years.

Te Aka, a new 15-bed facility, was opened in 2017. In addition, we have recently opened E Tū Tanekaha, a 15-bed unit and are currently in the design phase for the next facility, E Tū Wairua Hinengaro, a 30-bed unit. A business case for the second stage of E Tū Wairua Hinengaro, a further 30-bed unit, is being considered by the Ministry of Health.

The vision of the Mason Clinic site master plan is to provide an integrated campus, with a more open and accessible central area to improve its function, provide flexibility for future development and promote the treatment and rehabilitation of patients.

A key feature of the site master plan is the application of solutions to deliver models of care in an improved environment.

The site master plan addresses three main problems:

1. To replace leaky buildings at the earliest possible opportunity.
2. To support existing and evolving models of care.
3. To provide for additional capacity over the long-term.

Reports, correspondence and other documents relating to the capacity of the Mason Clinic, a shortage of beds and plans to increase the number of beds are provided as follows:

Annexure 1 – Letter from CEO to Director of Mental Health 2015

Annexure 2 – Te Aka original business case 2015

Annexure 2a – Updated Te Aka business case

Annexure 3 – Tanekaha replacement project 2016

Annexure 4 – Letter from CEO to Director General of Health 2018

Annexure 5 – Mason Clinic master site plan 2018

Annexure 6 – Ombudsman's office letter regarding intellectual disability unit investigations*

Annexure 7 – Ombudsman's office Terms of Reference regarding intellectual disability unit investigations*

Annexure 8 – Mason Clinic redevelopment programme business case 2019

Annexure 9 – Letter from Minister of Health to Board Chair.

*The reports in to these investigations can be found on the Ombudsman's website at:

<https://www.ombudsman.parliament.nz/resources/oversight-investigation-ministry-healths-stewardship-hospital-level-secure-services>

As previously mentioned, the business case application for the second stage of E Tū Wairua Hinengaro is currently with the Ministry of Health. We are declining to provide this document under section 18(d) of the Official Information Act as this information will soon be publicly available.

You have the right to seek an investigation and review of this decision by the Ombudsman. Information about how to seek a review is available at www.ombudsman.parliament.nz or Freephone 0800 802 602.

4. Current bed capacity.

The following table below provides a breakdown of the number of beds in each inpatient unit within the Mason Clinic facility.

In total, there are 126 beds on the hospital site. Of note, there are two individuals within the forensic intellectual disability service with very specific care needs, who each reside in a two-bed 'pod'. This has been negotiated with the Ministry of Health. Therefore, effectively the site's full capacity is 124 beds.

Table 1: Mason Clinic bed capacity by unit

Mason Clinic ward	Level of care	Capacity
E Tū Tanekaha	Rehabilitation Service Medium secure (Male and Female)	15
Kahikatea	Rehabilitation Service Minimum secure (Male only)	18
Kauri	Acute Service Medium secure (Male only)	15
Pohutukawa	Intellectual Disability Medium Secure (Male only)	12
Rata	Medium secure (Male only)	15
Rimu	Rehabilitation Service Open Hostel (Male and Female)	9
Tane Whakapiripiri	Kaupapa Māori Service Minimum Secure (Male and Female)	12
Te Aka	Kaupapa Māori Service Medium secure (Male and Female)	15
Totara	Mixed Acute and Rehabilitation Service Medium secure (Male and Female)	15

Mason Clinic ward	Level of care	Capacity
Total		126

5. Number of patients as at 30 June 2021 for the previous 10 years, by year.

The overall capacity of the Mason Clinic site has remained static from 2017 to 2021 but bed numbers within specific units have been configured to optimise patient care.

Please note that cross-sectional occupancy reports from a single day do not reflect the reality of day-to-day fluctuations as patients move in or out of a specific unit.

The table below details the number of patients in each ward on 30 June for the last 10 years.

Table 2: Number of tangata whai i te ora in each unit of a 10-year period

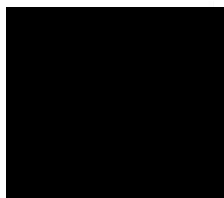
Mason Clinic ward	Calendar year									
	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Kahikatea	18	20	18	20	21	19	20	20	21	18
Kauri	13	14	16	14	13	15	16	15	15	15
Pohutukawa	9	11	10	10	10	11	10	10	9	10
Rata	15	16	15	17	14	15	15	14	14	14
Rimu	11	11	10	11	10	9	9	9	8	8
Tane Whakapiripiri	9	11	11	9	11	11	13	13	11	12
Totara	15	15	15	16	13	12	13	13	14	12
Tanekaha ¹	12	12	11	12	11	12	0	0	0	0
Te Aka ²	0	0	0	0	0	0	10	14	13	13
E Tū Tanekaha ³	0	0	0	0	0	0	0	0	0	14
Total	102	110	106	109	103	104	106	108	105	116

I trust that this information is helpful.

Waitematā DHB supports the open disclosure of information to assist community understanding of how we are delivering publicly funded healthcare. This includes the proactive publication of anonymised Official Information Act responses on our website from 10 working days after they have been released.

If you consider there are good reasons why this response should not be made publicly available, we will be happy to consider your views.

Yours sincerely



**Director, Specialist Mental Health and Addiction Services
Waitematā District Health Board**

¹ Tanekaha was decommissioned in August 2017

² Te Aka was commissioned in 2017

³ E Tū Tanekaha was commissioned in April 2021



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8 May 2015

Dr John Crawshaw
Director of Mental Health
Chief Advisor
Ministry of Health
PO Box 5013
WELLINGTON

Dear John,

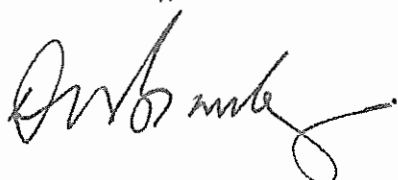
Re: Planning for the future of inpatient forensic mental health services in the Northern Region

Thank you for your letter of 28 April and enquiry regarding progress the scoping of options for continued provision of forensic services in the Northern Region. We have commissioned an external investigation that will culminate in a report to the District Health Board. In turn the findings and recommendations will be provided to you and, as agreed in January, to the Minister for Corrections and Associate Minister of Health the Hon Peseta Lotu-liga. The report will provide analysis of future demand for forensic services in the region, both mental health and intellectual disability. It will also explore options for the location of northern region forensic services (including future demand) to include the current site, the current site with additional land and external sites. This report is planned for completion in July 2015 and will be available to you as soon as it has been through the Board process which may take up to a further 6 weeks.

At our meeting in January we also discussed the Ministry position on forensic security rating issues in New Zealand and your view on the need for a maximum security forensic service for the country. I understand that you will be contributing to the security review process for the Mason clinic and hope that we will be able to get clear advice at that point in order to plan appropriately for the scale of works required in the remediation process.

I have asked Ian McKenzie and Jeremy Skipworth to liaise with you regularly to ensure you are kept up to date with progress on the options analysis development, report and security review. We welcome any support and participation your office can give.

Yours sincerely,



Dr Dale Bramley
Chief Executive Officer
Waitemata District Health Board

Mason Clinic – Increasing Regional Forensic Psychiatric Capacity

Mason Clinic Increasing Forensic Psychiatric Capacity

Mason Clinic – Increasing Regional Forensic Psychiatric Capacity

Document Version:	2.0 24/08/2015
Business Case Owner:	Ian McKenzie – General Manager, Mental Health Services
Input Provided By:	Sylvia Meakin – Hunter Group Ltd Bruce Talbot - Associate Service Manager Pam Lightbown – Service Manager Ian McKenzie – General Manager, Mental Health Services Steven Yee – Finance Manager Allan Johns – General Manager, Facilities Robert Paine – Chief Financial Officer
Business Case endorsed By:	Project Business Case Team [23/07/2015]
	WDHB Senior Management Team [06/08/2015]
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	WDHB Board consideration [12/08/2015]
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1. Executive Summary

1.1 Purpose of the Business Case

This business case is a refresh of the 2014 business case for a 15 bed Medium Secure Unit. The business case, which identified a project cost of \$9.8m, was approved by the Board in July 2014.

The need for a revised business case has arisen due to the project cost increasing from \$9.8m to \$14.443m, driven by an increase in size and financial escalation. As the revised cost is beyond the \$10m threshold for Ministry of Health and Treasury engagement, this business case has been developed to meet the requirements of the NZ Treasury Better Business Case approach for capital investments.

This business case seeks Board approval for the increased funding required to build a permanent 15-bed medium secure unit, with second level office accommodation, on the Mason Clinic site currently occupied by the Puriri building (the administration block). It elaborates on the planning undertaken for the 2014 business case and describes the changes which have resulted in an increase in costs to \$14.443m.

This business case is one of three interlinked proposals for investment in the Mason Clinic facility: the need for additional capacity (this proposal); the resolution of weather-tightness issues (the Remedial Works project); and resolution of the car parking shortfall on the Mason Clinic campus.

Auckland Council regulations require additional car parking to be provided in order for any expansion of capacity to be approved on the Mason Clinic site. Appropriate resolution of car parking for the campus is therefore a critical issue for the project. However, there are a number of unresolved issues that could mitigate the need for a car park. If these issues are not resolved, the facility proposed in this business case could be utilised as the temporary decant facility as planned, but it would not be able to be used as permanent *additional* capacity post the decant phase.

1.2 Business Case/Project Proposal

The proposed investment would create a permanent 15 bed medium secure unit to accommodate the known increase in demand for the medium secure forensic psychiatric services.

The building would initially function as a decant facility to support the Remedial Works project. This would allow the decant of the existing buildings in turn, enabling remediation works to be undertaken without the need for further investment in temporary decant capacity. This is expected to reduce the write-off costs of the associated Remedial Works project by the cost of the temporary building, approximately \$4.2m.

1.3 Key Drivers for the Project

The proposed investment addresses two key issues faced by Waitemata District Health Board (WDHB) regional forensic psychiatry services:

- The need for additional capacity to meet increased demand arising from: the increase in patients with high and complex needs; the opening of the Auckland South Corrections Facility (ASCF) in May 2015; and the planned repatriation of patients from Capital and Coast DHB (CCDHB) Forensic Psychiatric Unit;

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- The requirement to provide alternative facilities to enable the decanting of existing buildings, to allow urgent remedial works to be undertaken.

1.4 Key Objectives and Benefits of Implementing the Project

Three key Investment Objectives were developed for the proposed investment in additional capacity:

- To provide ongoing capacity to accommodate increasing number of patients with high and complex needs (5 beds), increase in prison muster (5 beds) and (at the request of the Ministry of Health) repatriation of patients from CCDHB (5 beds);
- To provide appropriate regional forensic psychiatric services for Northern Region patients, within the Northern Region area;
- To support the improvement in overall Regional Forensic Psychiatric Services building quality by accommodating decanted patients for the duration of the Remedial Works project.

The primary benefit of the proposed investment would be the creation of sufficient capacity to meet the projected growth in demand. This would result in a reduction in the number of people waiting for inpatient acute and sub-acute treatment and eliminate the need to transfer patients out of area, thereby enabling patients to maintain links within their community, including family, friends and other support.

The expected waiting times targets (once remediation work is completed and the capacity is available) would be as follows:

- Number of patients on waiting list for inpatient care (acute/subacute): ≤20
- Number of acute patients waiting over 6 weeks for admission: 0
- Number of sub-acute patients waiting over 3 months for admission: 0

A further very significant benefit from this investment would be the creation of capacity to facilitate the decant of the existing buildings, to enable remediation works to be undertaken without the need for further investment in temporary decant capacity. Whilst this is not a primary driver for this investment (the need to invest in additional capacity exists irrespective of the Remedial Works project), this project is critical to the Remedial Works project as it provides the decanting solution required to enable that project to proceed. The use of the permanent facility for decanting is expected to reduce the write-off costs of the Remedial Works project by the cost of a temporary decant facility, saving approximately \$4.2m.

1.5 Summary Options Analysis

Options analysis was undertaken to determine the preferred way forward. This analysis considered the number of beds (10 or 15), temporary or permanent facility, potential locations (on or off site) and service delivery options (in-house, retention of CCDHB beds and outsourcing).

The preferred option was a new build 15 bed unit on site. The need for additional office space was considered as part of the analysis and this has been costed as part of the proposed investment.

Since the 2014 business case was approved, further analysis has been undertaken by Synergia, on demand for services and the long term retention of the regional forensic psychiatric service on the current site. This analysis has determined that the most viable scenario is to retain the current site, with some expansion on

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a secondary site. The proposed investment in the 15 bed medium secure unit on this site is therefore aligned with the retention of services on this site, and remains the preferred option in spite of the increase in costs identified for the development of this facility.

1.6 Summary Project Capital Costs and Proposed Project Financing

The total project capital cost, based on the preferred option of a permanent 15-bed medium secure unit with office space is \$14.443m, as detailed in Table 1.

Table 1: Project Capital Costs

Description of Cost	\$
Unit build with GFA of 1772m ²	9,757,000
Demolition	127,000
Infrastructure	500,000
Fees and consents	1,746,000
FF&E	500,000
IT (Health Alliance)	500,000
Contingency	1,313,000
Total Project Cost	14,443,000

The Board approved \$9.8m for this facility in 2014; however protracted negotiations over land, a buoyant construction market and an increase in the unit size have seen the cost increase by \$4.643m. The revised estimated capital cost of the new facility is \$14.443m. It is proposed that the additional \$4.643m is funded from WDHB cash reserves.

1.7 Summary Financial Analysis

Profit & Loss Statement

Table 2: Mason Clinic Additional Capacity - Profit and Loss

Cost of capital 8% \$000	Initial Investment	Financial Year					Total
		2015-20	2020-25	2025-30	2030-35	2035-40	
Total Investment Outflow	0	-14,443					-14,443
Incremental Revenue		13,762	27,168	28,554	30,010	31,541	131,035
Incremental Cost		-15,931	-28,628	-28,452	-28,146	-28,098	-129,255
Net Profit / (Loss)		-2,169	-1,460	102	1,864	3,443	1,780

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Net Present Value Statement

Table 3: Mason Clinic Additional Capacity - Net Present Value (NPV)

Discount Rate 8%	Initial Investment	Financial Year				
		2015-20	2020-25	2025-30	2030-35	2035-40
\$000						
Capital Cashflow		-14,443				
Operating Cash Inflows/-Outflows		4,515	5,836	6,034	6,463	6,914
Net Cashflow	0	-9,928	5,836	6,034	6,463	6,914
Cumulative Cashflow	0	-9,928	-4,092	1,943	8,406	15,319

The financial modelling of the 15 bed unit generates:

- A negative NPV \$1.0m. A negative NPV suggests that costs are greater than financial benefits over the project duration;
- A projected profit and loss which is favourable from 2025 onwards, due to additional demographic funding made available to operationalize the 15 beds on completion of remedial works;
- The net book value of the building would be \$12.4m on completion of the remedial works.

1.8 Summary of Key Risks, Constraints and Dependencies

The risks assessed as being the highest probability and highest impact for the success of the project are summarised in Table 4.

Table 4: Key Project Risks

Key Risks	Risk Management Approach
Car parking solution is not approved, preventing additional capacity from being utilised. This would prevent repatriation of patients from CCDHB and would drive an increase in waiting times.	Development of the business case and implementation of the solution prior to completion of remedial works programme. Internal review of investment priorities. Ongoing communication with Council.
Client scope change increases design/build timeline, cost or both. This would delay decanting, impacting the Remedial Works project timeline. Delay in opening additional permanent capacity to reduce waiting times and enable repatriation of patients from CCDHB.	Strong Project Manager control. Escalation process for change requests, requiring cost and project impact assessment prior to approval
Delay in receiving approvals results in an extended timeline, impacting ability to commence and complete decanting. Delay in opening additional permanent capacity to reduce waiting times and enable repatriation of patients from CCDHB.	Strong project manager control. Escalation process for change requests, requiring cost and project impact assessment prior to approval.
Time to build exceeds expected timeline, impacting ability to commence and complete decanting as well as delaying opening of additional capacity to reduce waiting times and enable repatriation of patients from CCDHB.	Planning and design is underway, prior to receiving approvals. Strong project management and penalties for the builders for delays in completion.

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The key project constraints for the proposed investment are:

- Capital budget: the funding is constrained by other pressures on the WDHB capital available;
- Operational budget: the operational funding is constrained by other pressures on WDHB operational funds and the funding agreed with Ministry of Health for the additional capacity (15 beds);
- Timeline: Facility to be operational by February 2017 to enable decanting for Remedial Works project.

The critical dependency for the proposed investment is the resolution of the car park shortfall on the Mason Clinic campus. If this is not resolved, the additional capacity proposed in this business case cannot be utilised.

The number of car parks required is currently unclear, as the Council may require an increase in capacity for the whole site to meet the proposed Auckland Plan requirements. The potential number varies from 15 spaces (for administrative spaces only) to 96 spaces (for the new facility and increase to the existing capacity). Based on Quantity Surveyor estimates as at July 2015, the cost could vary between \$450k and \$3.5m. It is possible that this requirement may be mitigated or eliminated if some services were relocated to an alternative site. Further analysis of car parking requirements and potential solutions is required, and a business case for this will be brought to the Board in due course.

1.9 Summary Project Implementation Timeframes

The key project milestones and indicative dates are shown in Table 5.

Table 5: Key Project Milestones and Indicative Dates

Key Milestones	End Date
Business Case approval	Jul - Sep 2015
Design	Feb - Dec 2015
Tender	Oct 15 – Jan 16
Building consent	Dec 15 – Feb 16
Construction	Feb 16 – Jan 17
Commissioning	Jan - Feb 2017
Facility operational	Feb 17

Mason Clinic – Increasing Regional Forensic Psychiatric Capacity

1.10 Conclusion and Recommendation

The Mason Clinic is beyond capacity and demand is increasing. Patients waiting for admission for acute and sub-acute inpatient care are being held in inappropriate facilities. Since 2013, patients have been transferred out of area as the lack of capacity has prevented timely and appropriate access to services. Excessive waiting times are impacting the quality of patient care, resulting in patient health deteriorating, increasing costs associated with increased acuity and, ultimately, poorer health outcomes.

Demand will continue to grow, with the additional demand from growth in prison muster and population growth, driving an increase in the number of people with high and complex mental health needs.

At the same time as demand is increasing, the existing Mason Clinic buildings require urgent major remedial works to resolve significant weather-tightness issues and associated health and safety risks to patients and staff. In the absence of a permanent facility, temporary decanting capacity would be required at an estimated cost of \$4.2m.

By investing in a permanent facility, WDHB would create a facility which can meet both the temporary need to enable decanting and remediation of existing facilities, and provide capacity for the known increase in demand which cannot currently be met.

The capital cost of the proposed facility is \$14.443m. The Board approved \$9.8m for this investment in July 2014. It is recommended that the Board:

- (i) Endorse the Business Case for presentation at the September meeting of the Capital Investment Committee.
- (ii) Note that this is a refresh of the Business case endorsed by Waitemata DHB in July 2014
- (iii) Note the paper Mason Clinic Leaky Buildings Remediation and Repair Work Programme (previous agenda item) will be appended to the Business Case as a context paper
- (iv) Approve the uplift in budget to \$14.443m for the construction of the 15 bed inpatient unit, funded from cash reserves and enhanced additional Ministry of Health revenue for increased forensic demand.

Mason Clinic – Increasing Regional Forensic Psychiatric Capacity

2. Project Proposal and Background

2.1 Business Case Proposal

This business case seeks Board approval for increased funding of \$4.643m from WDHB cash reserves (to uplift the \$9.8m approved by the Board in July 2014) to build a permanent 15-bed medium secure unit, with second level office accommodation, on the Mason Clinic site currently occupied by the Puriri building (the administration block).

The proposed investment addresses two key issues faced by WDHB forensic psychiatry services:

- The need for additional capacity to meet increased demand arising from: the increase in patients with high and complex needs; the opening of the Auckland South Corrections Facility (ASCF) in May 2015; and the planned repatriation of patients from Capital and Coast DHB (CCDHB) Forensic Psychiatric Unit;
- The requirement to provide alternative facilities to enable the decanting of existing buildings, to allow urgent remedial works to be undertaken.

The proposed investment is for the establishment of a permanent facility, to provide a 15 bed increase in capacity. The investment would also support the Remedial Works project by facilitating the decant of the existing buildings in turn, enabling remediation works to be undertaken without the need for further investment in temporary decant capacity. This is expected to reduce the write-off costs of the associated Remedial Works project by the cost of the temporary building, approximately \$4.2m.

2.2 Background

This business case is a refresh of the 2014 business case for a 15 bed Medium Secure Unit. The business case, which identified a project cost of \$9.8m, was approved by the Board in July 2014.

The need for a revised business case has arisen due to the project cost increasing from \$9.8m to \$14.443m, driven by an increase in size and financial escalation. As the revised cost is beyond the \$10m threshold for Ministry of Health and Treasury engagement, this business case has been developed to meet the requirements of the NZ Treasury Better Business Case approach for capital investments. It elaborates on the planning undertaken for the 2014 business case and describes the changes to the 2014 proposal which have resulted in an increase in costs to \$14.443m.

This business case builds on two previous business cases for investment in the Mason Clinic regional forensic services, to improve and upgrade existing building stock and infrastructure and to increase capacity to accommodate the expected growth in demand for forensic psychiatry:

- **Mason Clinic Remedial Works Business Case** 12 November 2012
- **Mason Clinic: 15 Bed Medium Secure Unit** 16 July 2014

Mason Clinic – Increasing Regional Forensic Psychiatric Capacity

In December 2012, a business case was presented to the Board, identifying the need for investment to undertake remedial work to resolve weather-tightness issues in a number of the Mason Clinic (Regional Forensic Psychiatry Service) buildings. The need for a suitable 10 bed decant facility was identified at that time, to enable building repairs to be made sequentially whilst maintaining safety and service levels. At that time, the intention was for the decant facility to be at Waitakare Hospital as there was no suitable building or capacity on the Mason Clinic site. The business case was approved by the Board in December 2012.

In January 2013, an option to lease or purchase land at Unitec was presented to the Executive Committee Meeting (of the Board). This would have allowed the building of a decant facility adjacent to the Mason Clinic. This approach was supported by the Board and the Ministry of Health (MoH) and negotiations with Unitec commenced. Unitec subsequently indicated that they did not wish to sell the land under negotiation, and therefore a lease was signed in November 2013.

Whilst negotiations were underway on the sale/lease of the Unitec land, further demand and capacity analysis was undertaken. In March 2013, pressures on capacity resulted in the purchasing of 5 beds at Capital and Coast DHB. Late in 2013, the Northern Region sponsored a related project regarding the shortage of options for people with high and/or complex needs. The review identified a significant gap in capacity, resulting in a recommendation for the development of 5 additional beds in the decant unit. In addition, the planned opening of the Auckland South Corrections Facility (ASCF) would further increase the gap between capacity and demand, by an estimated 5 beds. The Ministry of Health confirmed funding for the 15 additional bed capacity required¹.

At this point, the focus was changed from a temporary decant facility, to a permanent facility with capacity to meet growing demand. This unit would be used in the short-term as the decant facility, enabling the essential remedial works to be undertaken to the existing Mason Clinic buildings.

In August 2014, the Board approved the business case for the construction of a (permanent) 15 bed Medium Secure Unit at the Mason Clinic. The project had an approved budget of \$9.8m (of which \$2.5m had been approved in an earlier decision regarding remedial works for the construction of a temporary facility solely for decanting purposes).

The figure of \$9.8m was based on a conceptual Gross Floor Area (GFA) estimate of 1600m². Since the 2014 business case was approved, the design has been further developed following a detailed review of the proposed site and proposed Model of Care with WDHB staff. The GFA estimate has increased by 172m², the smallest compliant footprint that could be achieved without adversely impacting service delivery. This includes an increase in bedroom size from 9m² to 12m² (in line with Australasian Health Facility Guidelines), provision of a facility for women to access bedroom and living areas and access a female only courtyard, increased plant and equipment areas and an additional stairwell and lift access. These changes are summarised in Appendix 1.

In July 2015, a paper was presented to the Board detailing the increase in costs from \$9.8m to \$14.1m (see Appendix 1). The increase in costs, since the approval of \$9.8m for this facility in 2014, is summarised in Table 6.

¹ Letter from Chai Chuah, Acting DG Health to Dale Bramley CEO, 4th November 2014 [Actions to address bed pressures at the Mason Clinic](#)

Mason Clinic – Increasing Regional Forensic Psychiatric Capacity

Table 6: Summary of Cost Change between Business Cases

Description of Cost	\$	
	2014	2015
Unit build	1600m ² 7,200,000	1772m ² 9,757,000
Demolition	75,000	127,000
Infrastructure	375,000	500,000
Fees and consents	1,165,000	1,746,000
FF&E	Not included	500,000
IT (Health Alliance)	Not included	500,000
Contingency	885,000	1,313,000
Total Project Cost	9,700,000²	14,443,000

2.3 Associated Investment Proposals

This business case is one of three interlinked proposals for investment in the Mason Clinic facility: the need for additional capacity (this proposal); the resolution of weather-tightness issues (the Remedial Works project); and resolution of the car parking shortfall on the Mason Clinic campus.

Auckland Council regulations require additional car parking to be provided in order for any expansion of capacity to be approved on the Mason Clinic site³. Appropriate resolution of car parking for the campus is therefore a critical issue for the project. If this issue is not resolved, the facility proposed in this business case could be utilised as the temporary decant facility as planned, but it would not be able to be used as permanent *additional* capacity post the decant phase. The new unit would have to replace an existing unit of comparable size, i.e. overall bed capacity (and therefore staff numbers) would remain unchanged.

The number of car parks required is currently unclear, as the Council may require an increase in capacity for the whole site to meet the proposed Auckland Plan requirements. The potential number varies from 15 spaces (for an administrative spaces only) to 96 spaces (for the new facility and increase to the existing capacity). The scenarios and indicative costs are summarised in Table 7. The additional car parking is associated with additional office capacity (beyond that which is planned for the second level of the 15-bed unit), so that both the additional staff for the new capacity, and the staff displaced from Puriri, can be accommodated.

However, the requirement for additional car parking and office capacity may be mitigated, if not eliminated, if some services were relocated to an alternative site. Further analysis of car parking requirements and potential solutions is required, and a business case for this will be brought to the Board in due course.

² Note that the amount approved in 2014 for the building of this facility was \$9.8m, although the costs (as outlined in Table 6) were estimated at \$9.7m.

³ John Childs, Resource Management and Town Planning Consultants, 19 June 2015.

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Table 7: Car Parking Scenarios and Indicative Costs

Scenario	Indicative \$000 ⁴
15 spaces – additional administrative office space (on grade)	\$450
31 spaces – 15 bed unit only (one deck)	\$1,116
46 spaces – 15 bed unit + admin (two decks)	\$1,440
96 spaces – 15 bed unit + admin + increase existing capacity (two deck)	\$3,480

3. Project Drivers

3.1 Current State

Existing Forensic Mental Health Services

WDHB provides Auckland Regional Forensic Psychiatric Services from the Mason Clinic campus, located on Carrington Road in Point Chevalier, Auckland. Forensic psychiatric services are provided to WDHB residents as well as residents of other Northern Region DHBs.

- **Inpatient Assessment and Treatment of Mentally Disordered Offenders:** The clinic provides integrated forensic mental health services, including assessment and treatment of mentally disordered offenders or alleged offenders as identified in the Northern region's courts, prisons and general mental health services.

Whilst inpatient beds are nationally top-sliced and are therefore technically available for patients from anywhere in the country, in practice demand is so high in the Northern region that the admission of patients from out of region to the Mason Clinic seldom occurs. The length of stay of patients or service users receiving assessment, treatment and rehabilitation ranges from a few days to several years.

The Mason Clinic campus includes eight in-patient units and an intellectual disability unit that assesses, treats and assists in the recovery of people with mental illness or intellectual disability who have committed a criminal offence or are at high risk in the community. The inpatient units range from minimum security to high security with a current capacity of 106 beds.

The campus also has non-inpatient units including an Administration Centre (Puriri building), a Cultural Centre, Community Outpatient Base (for staff working in Community teams, Courts and Prison Mental health teams), a swimming pool and associated outbuildings all within a single campus of 3.9 hectares. The Mason Clinic facilities are summarised in Table 8.

⁴ Rider Levett Bucknall 27th July 2015

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Table 8: Mason Clinic Facilities

Unit Name	Description
Pohutukawa	10 bed medium secure unit used for the assessment & rehabilitation of intellectually disabled offenders. 2 assessment beds Office space for Quality/Education team and Intellectual Disability community liaison team.
Tane Whakapiripiri	10 bed minimum secure Kaupapa Maori rehabilitation unit.
Tanekaha	10 bed minimum secure rehabilitation unit.
Rata	15 bed long term secure rehabilitation unit
Kahikatea	20 bed minimum secure rehabilitation unit
Kauri	15 bed medium secure admission units
Totara	15 bed medium secure admission units
Rimu	9 step down bed hostel
Kowhai Building	Office space for Court Liaison and Community Forensic Teams. Also Chaplains and Consumer Advisors.
Puriri Building	Administration block with Service Management, Clinical Director, Medical Records and Prison Team
Te Miro	Maori and Pacific Nations Resource Centre, office space for some cultural advisors

Other Regional Forensic Mental Health Services provided by WDH B include:

- **Community Forensic Services:** Forensic Consultation Liaison Services are provided to local Mental Health Services regionally and assistance is given in developing and implementing effective plans for risk assessment management. The Community Forensic Team provides clinical care for clients in the “step down” beds; case manages high risk forensic clients in the community and ensures that there is an appropriate transition of clients from the forensic inpatient units to local Mental Health Services.

Twenty step-down beds are provided in the community, in partnership with Non-Governmental Organisations (NGOs): 5 Pacific Nations Beds; 5 Kaupapa Maori Beds; and 10 Mainstream Beds.
- **Intellectual Disability Offenders Liaison Service:** This team provides care under Intellectual Disability Compulsory Care and Rehabilitation Act, 2003 for people who are referred by the Regional Intellectual Disability Community Care Agency (RIDCA). There is a 10 bed intellectual disability secure unit at Mason Clinic, one of the two National Intellectual Disability Support Service (NIDSS) units in the country serving the upper half of the North Island for intellectually disabled offenders. There is also a four Full Time Equivalent (FTE) community Intellectual Disability (ID) liaison team.
- **Court Liaison Team:** Has a presence in every major Court in the Auckland and Northland regions. Court Liaison’s primary functions are to provide psychiatric assessment and informal advice to the Court on the appropriateness of formal psychiatric reports and/or diversion to Mental Health Services.
- **Forensic Prison Team:** A multi-disciplinary team provides tertiary clinical services into prisons. The team manages an inmate caseload, receives referrals from Prison Health Services and facilitates the transfer of mentally unwell inmates to hospital for care and treatment.

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3.2 Drivers for Investment

In September 2011, an Investment Logic Mapping (ILM) process was undertaken to help stakeholders define the key problems faced by forensic psychiatric services. These problems are summarised below and the map arising from the process is attached as Appendix 2.

- Increasing exposure to structural faults and environmental hazards heightens the risk of serious harm;
- Increasing inability to provide care for all patients in an appropriate facility increases the risk of avoidable harm (and poorer patient outcomes);
- Delaying repairs to buildings will increase costs and threaten the viability of the services;
- Failure to meet duty of care requirements will result in a critical loss of confidence in the service.

The two key issues: the increasing inability to provide care for all patients in an appropriate facility (demand exceeding capacity) and failing buildings are further detailed below.

Increasing Demand

Demand for Regional Forensic Psychiatric Services (RFPS) at the Mason Clinic is increasing and cannot be met within existing capacity. The service has been operating at over 100% bed occupancy for some years and has a significant waiting list of unwell prisoners requiring tertiary hospital-level care.

The key issues for forensic services arising from capacity constraints are:

- The Northern Region prison muster is projected to grow from 2,014 prisoners in 2009, to over 3,000 prisoners over the next 1-2 years from 2015 – this growth cannot be accommodated within existing facilities.
- Services are operating at over 100% occupancy (achieved by admitting some clients into seclusion areas and by changing activity areas into bedrooms) and there is a waiting list for admissions. Since 2013, patients have been transferred to 5 beds purchased at Capital and Coast DHB as there is insufficient capacity locally, even with these arrangements.
- The waiting list on the Northern Region is the most extensive nationally and many people on the waiting list are never admitted to the Mason Clinic. A large proportion of people wait for their hospital treatment until they are released or bailed, so that they are then able to access care through local mental health services. Between January and July 2015 (27 weeks), there were only 7 weeks where there were no patients waiting for sub-acute care (average number of patients waiting was 1-2). In the same period the average number of patients waiting for acute care was 5, ranging from 1 to 10 in each weekly period.
- Delays in admitting people to the Mason Clinic have caused the health status of some patients to deteriorate, resulting in increased clinical complexity and associated cost.
- Failure to make adequate provision for the care of these people has the potential to expose both the Board and the Government to risk. The service gap has previously been highlighted in the media.
- Clinical staff are exposed to clinical and professional risk as treatment options become limited for those people whose only access to inpatient mental health treatment is within the Mason Clinic.

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Growth analysis has been undertaken to evaluate the future demand for RFPS based on the three key factors impacting demand: population increase driving a growth in patients with high and complex needs; the opening of additional prison facilities in the region; and the repatriation of patients from the Wellington region. The impact of this demand on bed number requirements is summarised in Table 9. A summary of 10 year projections of supply and demand for Mason Clinic facilities is attached as Appendix 3.

Table 9: Projected Additional Beds Required at Mason Clinic

Demand Source	Summary	Beds Required
Growth in patients with High and Complex Needs	The four Northern Region DHBs (Counties Manukau, Auckland, Waitemata and Northland) account for over a third of the New Zealand population. Census returns show that the Northern region is experiencing a higher growth rate than the rest of New Zealand, has the largest migrant population and greatest inequalities for Maori and Pacific peoples accessing services. The project population growth to 2031 is shown in Figure 1. The population growth is driving an increase in referrals to RFPS, from both courts and prisons.	5
Prison muster growth	The prison muster numbers are expected to grow significantly during 2015, with the progressive opening of the ASCF beds and the proposed increase in capacity at the Mount Eden Corrections Facility (MECF). The RFPS will provide services to 3560 prisoners in the Northern Region. This is the highest number of prisoners in the country and is a growth of 1035 prisoners. The growth in prison capacity is shown in Figure 2. To support this expansion, the RFPS beds will increase by 5 and the Prison Team will increase by 12 FTE progressively through until 2020. Funding for this is approved by MoH. With this increase in the muster, the flow through of prisoners requiring hospitalisation has resulted in agreement between WDHB and MoH to establish 5 additional beds, with the associated funding stream.	5
Repatriation of patients from Capital and Coast DHB	CCDHB are currently funded to provide 5 beds, operating as an overflow to RFPS. This temporary solution was put in place to address the growing wait list in the Auckland Region and to allow remedial works to be undertaken. This arrangement commenced in March 2013 with agreement that once capacity was in place in the Auckland Region, the patients would be repatriated.	5
TOTAL		15

The RFPS is critical to the provision of corrections services. Forensic prison mental health teams have access to information on prisoners to enable them to make a comprehensive clinical assessment of the needs of those prisoners. RFPS coordinates meetings with all involved agencies to address the needs of prisoners designated at risk or suffering from mental health issues, in a timely manner to ensure safe management. Growth in prison muster numbers directly impacts on RFPS, as the RFPS has to increase capacity to ensure safe management of prisoners within the correctional facility, as well as providing sufficient beds for those prisoners who require more intensive support.

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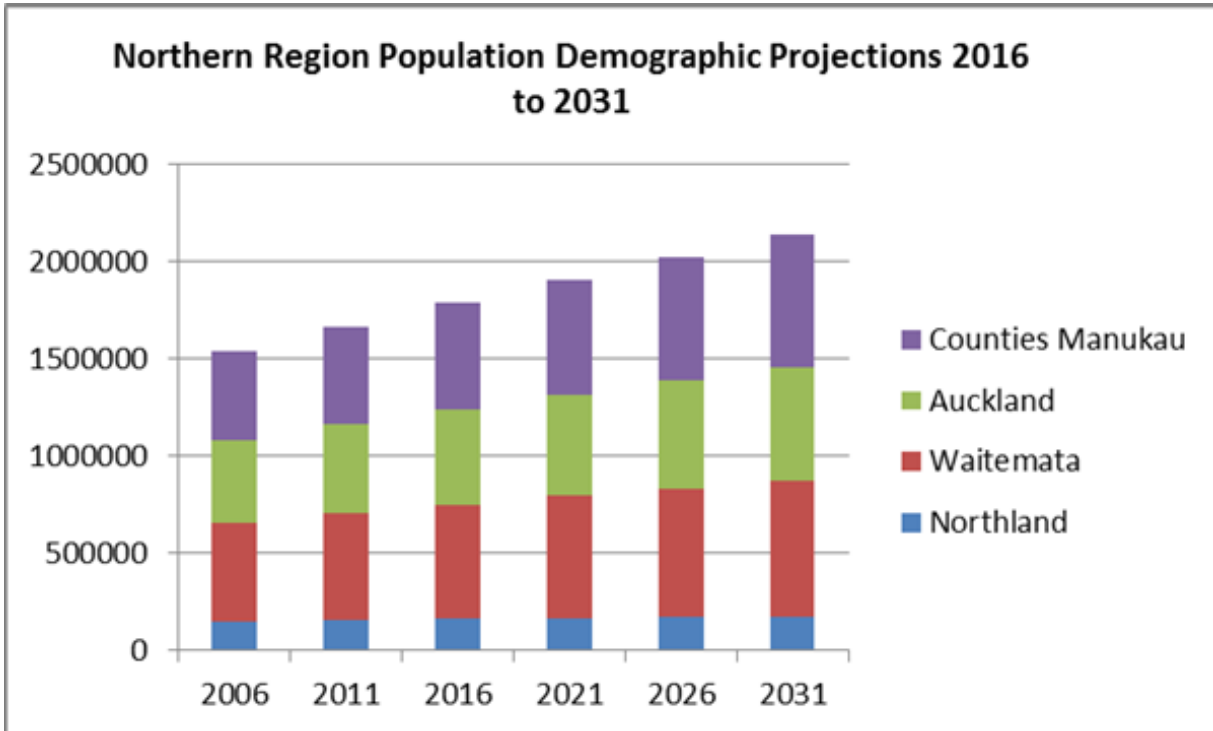


Figure 1: Northern Region Demographic Projections 2016 - 2031

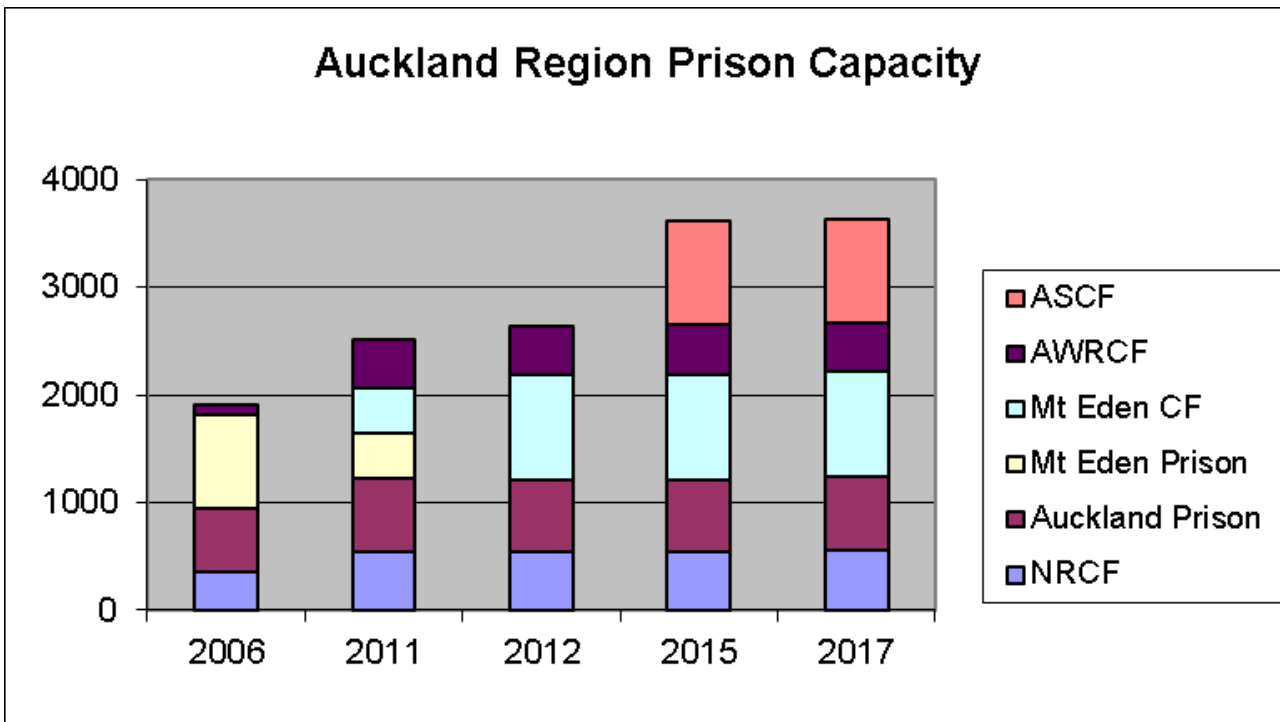


Figure 2: Auckland Region Prison Capacity

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Failing Buildings

The Mason Clinic campus comprises ten low rise purpose designed and built clinical buildings constructed since 1993, with the latest new build opening in 2005. Three buildings have a floor area of approximately 1,000m², two buildings are approximately 1,500m² and the remaining five range in size from 300m² to 500m². Several buildings are of two storeys. The buildings are of mixed material construction, comprising stucco plaster, fibre cement weatherboard and sheet panels, plywood, corrugated iron and concrete block. A Mason Clinic campus map (pictorial view) is provided as Appendix 4.

During early 2011, it was observed that several buildings were failing significantly, suffering from leaking roofs, guttering and exterior walls. An expert building survey was carried out by Cove Kinloch to provide a report on what has now become a “leaking building” situation affecting almost all the buildings to varying degrees.

As a result of water ingress causing internal damage to the integrity of the buildings, several of the buildings have deteriorated to the point where three units have registered the presence of *Stachybotrys* fungus in some wall cavities as confirmed by air samples and testing undertaken by specialist laboratory Biodet. *Stachybotrys*⁵ is considered a highly dangerous fungus with potential to cause serious health problems. Bi-monthly testing by Biodet continues and in recent times has confirmed the presence of this fungus is minimal and currently at safe levels. However, due to the lack of weather tightness of the buildings, this may not continue and could result in a reading that requires immediate decanting of one or more of the units.

The leaky and weather tightness issues create an unacceptable risk to clients, clients’ families and staff health. This could render the buildings unfit for use, threatening continued ability to provide forensic mental health services. The buildings require major refurbishment and remedial works to make them fit for purpose and eliminate risk to patient and staff health and safety.

The clients in a number of the worst affected buildings need to be housed in high security buildings due to the nature of the crimes they have committed and they cannot be moved from the Mason Clinic without an application to the Courts. In addition, the prospect of high security clients detained under the Mental Health Act being transferred to other properties for the duration of the remediation works runs the almost certain risk of intense public scrutiny and resistance.

Availability of decanting space is a critical requirement for the remedial works programme, given the nature and security requirements of services provided in the buildings to be remedied. Limited decanting capacity means that remedial works will have to be undertaken over a longer timeframe of three to four years, with the most at-risk buildings being remedied first.

⁵ *Stachybotrys* is one of the most infamous toxic mould that can grow in houses and is extremely dangerous to humans. It can cause respiratory problems, skin inflammation, haemorrhage, damage to internal organs, mental impairment, irritation of mucous membranes, tiredness, nausea and immune system suppression.

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3.3 Future State - Investment Objectives

As part of developing the 2012 business case, key stakeholders identified a number of Investment Objectives. These were primarily related to the need for remediation, as this was the focus at that time.

A further set of Investment Objectives have been developed, relating specifically to the proposal for investment in additional capacity. The Investment Objectives for additional capacity, the existing arrangements and business needs are summarised in Table 10.

Table 10: Investment Objectives

Investment Objective 1: To provide ongoing capacity to accommodate increasing number of patients with high and complex needs (5 beds), increase in prison muster (5 beds) and repatriation of patients from CCDHB (5 beds)	
Existing arrangements	<ul style="list-style-type: none"> ▪ Cannot meet the current demand within the existing Northern Region capacity, resulting in patients being sent out of area (CCDHB) ▪ Progressive increase in prison muster will place pressure on current capacity ▪ Waiting time for access for Unit will grow, with patients being held in inappropriate facilities whilst awaiting placement ▪ Risk of adverse outcomes as increasing number of patients are held in inappropriate facilities
Business needs	<ul style="list-style-type: none"> ▪ Increase of 15 beds above current capacity, to meet projected demand ▪ Additional resource (FTEs) to support the increased bed numbers
Investment Objective 2: To provide appropriate regional forensic psychiatric facilities for Northern Region patients, within the Northern Region area	
Existing arrangements	<ul style="list-style-type: none"> ▪ Insufficient capacity in the Northern Region has necessitated purchase of 5 beds at CCDHB ▪ Difficulties for relatives visiting patients who are accommodated out of area ▪ Increased cost to WDHB, for transporting patients to and from CCDHB facility
Business needs	<ul style="list-style-type: none"> ▪ Capacity within the Northern Region to enable local (Northern Region) patients to be accommodated within the region
Investment Objective 3: To support the improvement in overall RFPS building quality by accommodating decanted patients for the duration of the Remedial Works project	
Existing arrangements	<ul style="list-style-type: none"> ▪ Urgent remediation is required to buildings with weather tightness issues ▪ There is no surplus capacity available to enable patients to be moved sequentially, to allow remedial work to be undertaken ▪ Patients are remaining in poor quality accommodation, creating Health and Safety risks for both patients and staff
Business needs	<ul style="list-style-type: none"> ▪ Medium secure facility with sufficient capacity to accommodate 15 patients ▪ Medium-high secure facility which meets H&S requirements, to enable subsequent sequential decant of patients from other units

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4. Project Benefits and Deliverables

4.1 Project Benefits

The main benefits of the proposed investment in forensic psychiatry capacity and facilities were identified as part of the development of the initial (2012) business case, with the overall aim of improving patient outcomes. These are shown in Figure 3 and described further in the following section. The original benefits map showing key performance indicators (KPIs) and measures is attached as Appendix 5⁶.

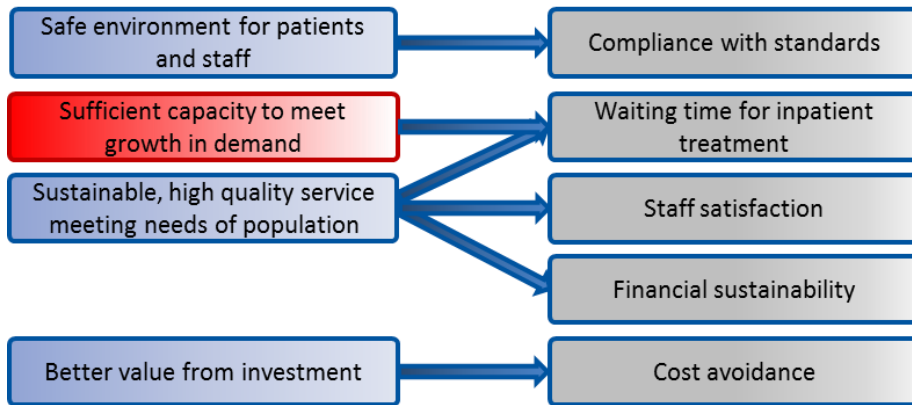


Figure 3: Benefits of Investment in Improving Forensic Health Services Facilities and Capacity

The investment in additional capacity proposed in this business case is focused primarily on realising the second benefit: meeting the actual and expected growth in demand for services.

The proposed investment will also be a critical enabler for the Remedial Works project, by operating as a decant facility during the remediation works. It will thus contribute to the safer environment for patients and staff. The benefits claimed from the remediation works are captured in the 2012 business case and, although referenced here, are not double-counted in this business case.

The primary driver for investment in additional regional forensic psychiatry capacity is not financial, and few direct financial benefits from the proposed investment have been identified. The key financial benefit would actually accrue to the Remedial Works project, as the building of the permanent facility proposed in this business case would eliminate the need for a temporary facility with its associated write-off costs.

Whilst some of the remaining benefits arising from the proposed increase in capacity could in theory be quantified financially by applying a set of assumptions, this has not been undertaken as the assumptions are likely to be very variable and subjective. Given the level of variability and subjectivity, it would be extremely difficult to quantify these benefits with an acceptable degree of robustness. Such financial impacts have therefore been excluded from the financial analysis.

The financial and non-financial benefits of investment in additional Regional Forensic Psychiatric capacity are described in Table 11.

⁶ The second benefit was identified during the ILM process but was not explicitly captured on the resulting benefits map. Given the increasing emphasis on growth in demand, it is reflected here and in the 2012 business case.

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Table 11: Financial and Non-Financial Benefits of Investment in Additional Forensic Psychiatry Capacity

Benefit	Description	Estimated Value
WDHB Forensic Psychiatry service capacity meets expected growth in demand	Once the decanting/remediation process is concluded, the facility would be used to house the 5 repatriated patients from CCDHB, 5 additional high and complex patients and 5 additional patients to meet demand from the Auckland South Corrections Facility.	Not financially quantified
Enable decanting for essential remediation works on existing buildings	The facility would be utilised as the decant facility, to enable patients to be decanted sequentially as remediation works on the existing buildings is undertaken. This would help ensure the continuity of service provision. These works are expected to be undertaken over a period of 3 years, commencing with the most seriously faulty buildings in 2017 ⁷ .	Not financially quantified
Improved service quality	<p>The investment in additional capacity will reduce waiting times for acute and sub-acute patients to access services. This will reduce the number of patients being held in inappropriate facilities whilst they are awaiting placement at the Mason Clinic. Waiting times Targets have been set as follows⁸:</p> <ul style="list-style-type: none"> • Number of patients on waiting list for inpatient care (acute/subacute): ≤20 • Number of acute patients waiting over 6 weeks for admission: 0 • Number of sub-acute patients waiting over 3 months for admission: 0 <p>Patients would no longer be sent out of area (to CCDHB) for care due to lack of capacity at the Mason Clinic. This would have a small financial benefit for WDHB, due to reduced transfer costs.</p> <p>Retaining patients within the Northern Region would also result in a significant benefit for patients, as the provision of care locally would facilitate maintenance of links with family and friends.</p>	Not financially quantified
Elimination of write-off costs for temporary decant facility	The write-off costs of a temporary decant facility would be eliminated if the proposed investment in a permanent facility is approved. The permanent facility would be utilised as the decant facility during the essential remediation works. Once concluded, the facility would be available to accommodate the expected increase in demand.	\$4.2m (Saving accrues to Remedial Works project)
Safe environment for patients and staff	By enabling decanting/remediation, this investment would: <ul style="list-style-type: none"> ▪ Support WDHB ability to continue to provide Regional Forensic Mental Health services from safe and secure premises; ▪ Enable existing facilities to comply with requirements of the Health and Disability Services Act. 	Benefits accrue to Remedial Works project
Sustainable, high quality service that meets the needs of the population	By enabling decanting/remediation, this investment would: <ul style="list-style-type: none"> • Ensure delivery of sustainable, high quality services that meet the needs of the population. 	
Better value from investment	By enabling decanting/remediation, this investment would: <ul style="list-style-type: none"> • Halt the decline in the value of the Crown's investment in the Mason Clinic (valued at \$36m prior to 30 June 2011, subsequently reduced by 	

⁷ The timeline assumes the proposed decant facility will be operational by this point.

⁸ These targets would be applicable once the unit is functional as additional capacity, not whilst it is functioning as a decant facility.

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	\$6m due to impairment of the buildings).	
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Disbenefits of Investment

The main disbenefits (downsides) of the proposed investment are summarised in Table 12.

Table 12: Disbenefits

Disbenefit	Summary
Unitec land value	Value of the Unitec land would be reduced, as a result of the presence, and growth, of the RFPS facility. The land would be less attractive as residential land, for prospective purchasers.
Reduced Capex and Opex for other projects	The investment in Mason Clinic facilities, including the new build, remediation and car parking, would reduce the availability of Capex and Opex for other projects.

4.2 Project Deliverables

The scope and service requirements for this investment range from minimum (essential to the success of the investment), through intermediate to maximum (if value for money and affordable). The summary of scope and service requirements is shown in Table 13. The preferred scope, based on requirements and potential value for money, is the Intermediate Scope. This includes all of the elements of the Minimum Scope, plus the sensory room.

Table 13: Scope and Key Service Requirements

Service Requirement	Minimum	Intermediate	Maximum	Out of Scope
15 bed permanent additional capacity	✓			
Whare Nui room	✓			
Office space for community teams/Prison in-reach	✓			
Lift access	✓			
Outside courtyard areas	✓			
Sensory room		✓		
Ensuites to all bedrooms			✓	
Spa pool/jacuzzi			✓	

5. Strategic Fit

5.1 Local Strategic Fit

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Waitemata DHB provides specialist regional forensic psychiatric services to meet the health needs of people with significant mental health needs, who are before the Courts or who are in the criminal justice system. The proposed additional bed capacity would increase the Mason Clinic’s ability to provide timely, high-quality services in an environment which is secure and safe. The alignment with specific local strategies and policies is summarised in Table 14.

Table 14: Alignment of Investment with Local Strategies and Policies

Strategy/Policy		Contribution
WDHB Mental Health and Addictions Service Development Plan 2009-15	High	<p>Holistic wider continuum of care: Holistic Care is the philosophy that guides this proposed investment. The aim is that the new service would incorporate physical, psychological, spiritual and cultural paradigms of care.</p> <p>Early intervention: The building’s close proximity to the current services, including access to prisons across the region, will improve access and increase the likelihood of early intervention.</p> <p>Information and resources: Information utilisation would be one of the key elements that assists the service in achieving the objectives that have been set and which are catalogued in the implementation plan.</p>
2014/15 Annual Plan	High	<p>Outcome – Reduced morbidity and mortality from Mental Illness: Increased capacity would enable timely access for prisoners and others with acute and complex mental health needs.</p> <p>Mental Health (Service Development Plan) Improved access to mental health services: Increasing capacity would support the DHB to meet its goal of improving access, as measured by maintaining or increasing the percentage of mentally unwell prisoner admissions to Forensic Inpatient Services.</p>
Retention of Mason Clinic site	High	<p>Analysis of future land requirements undertaken by Synergia Ltd, on behalf of WDHB, indicates that the most viable option is to stay at Mason Clinic site, with secondary site expansion.</p> <p>Cost of re-establishing existing Mason Clinic facilities on a new site is estimated \$182m, plus the additional \$14.443m identified in this business case⁹. Even if the decision was taken to relocate services, this would be over a ten year period as a minimum. The need for additional capacity during the period would remain and therefore the proposed investment is still valid.</p>
Health Services Plan	High	<p>The proposed investment is consistent with the Health Services Plan which is currently under development.</p>

5.2 Regional Strategic Fit

The proposed investment is aligned with expectations that WDHB will be continue to be capable of providing regional forensic services from clinically safe and fit-for-purpose facilities. There are limited facilities around New Zealand from which forensic psychiatric services can be provided, with WDHB holding the northern region contract for such services. These services support the justice and corrections institutions in the Northern Region. The alignment with regional strategies and policies is summarised in Table 15.

⁹ Synergia Ltd [Mason Clinic future land requirement investigation and options](#) July 2015, based on figures provided by Rider Levett Bucknall

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Table 15: Alignment of Investment with Regional Strategies and Policies

Strategy/Policy	Contribution
Northern Region Health Plan 2014	<p>Objective – Improve adult forensic capacity and responsiveness through the national forensic network: The increase in capacity would enable services to be more responsive to those in need. Waiting times would be reduced and out of area referrals eliminated.</p> <p>Objective – Increase capacity and improve responsiveness of mental health and addiction services for people with high and/or complex needs: The additional capacity would meet the growth in demand for services for people with high/complex needs.</p> <p>Objective - Determine appropriate forensic and general mental health and addiction services capability and capacity to meet the growing prison muster: The additional capacity is a critical support for the growing prison muster. The opening of the Auckland South Corrections Facility and the planned expansion of the Mount Eden Corrections Facility will both require additional forensic psychiatric capacity.</p>

5.3 National Strategic Fit

With the reconfiguration of corrections and the increased demand in the Auckland region resulting from the opening of the Auckland South Corrections Facility and proposed extension to the Mount Eden Corrections Facility, WDHB has become the largest provider of forensic services to corrections in New Zealand. The beds are seen by the Ministry as a nationally important resource and the increase in bed capacity is strongly supported by the Ministry/Director of Mental Health. The alignment with national strategies and policies is summarised in Table 16.

Table 16: Alignment of Investment with National Strategies and Policies

Strategy/Policy	Alignment of proposed investment
Te Kokiri: The Mental Health and Addiction Plan 2006-2015	<p>Building Mental Health Services: Service users need easy access to services: Increasing bed capacity near to the population served would enable better access to this service</p> <p>Responsive: Build services for people severely affected by mental illness, with emphasis on responsiveness: The new unit would be designed to meet the needs of the diverse adult population group. The design would use Australasian Health Facility Guidelines and National Health Service Department of Health guidelines regarding forensic services design and best practice. Clinicians are part of the design group.</p> <p>Maori Mental Health: Ensure continuity of care between mainstream and Kaupapa Maori mental health services: Maori have been involved in all aspects of the planning to date, and would continue to be engaged in detailed planning and implementation. Maori are part of the project steering group. The new unit would include a Whare Nui room. The protocols for this space would be developed with the Kaupapa Maori group.</p> <p>Creating an environment where mental health workers and service users can use information to support and enhance recovery: The design would use Australasian Health Facility Guidelines. Clinicians are part of the design team to ensure that the work environment meets the needs of clinical staff. Consumer advisers are part of the project Steering Group and have provided advice on promoting a recovery approach.</p>

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Destination Recovery and Our Lives in 2014	Medium	<p>Service users are involved in planning: Service user involvement in planning the re-build, through consumer advisors and family forums</p> <p>Measures or outcomes are based upon what is important for service users: Ongoing formal and informal consumer and family feedback</p>
New Zealand Health and Disability Services Standards NZS 8134:2008	High	<p>Provide an appropriate, accessible physical environment: Proposed plans meet with criteria set out in Standard 4. The new unit would meet standards, ensure the physical environment minimises risk and promotes safety.</p> <p>The unit would also enable the decanting, and sequential remediation, of buildings currently assessed as failing to meet the required standards.</p>
Te Rau Hinengaro	Medium	<p>Reduce barriers to health services for people with mental disorders: Local agreed pathways and protocols with primary, secondary and NGO providers will improve the continuum of care and reduce access barriers. Location of the planned unit is adjacent to the Tane Whakapiripiri Unit, keeping the Kaupapa Maori service connected.</p>

6. Critical Success Factors

The Critical Success Factors (CSFs) agreed for the 2012 business case were reconfirmed for this business case, with one amendment: ‘extent of benefits realised’ was revised to ‘potential value for money’. No proposal-specific amendments were made.

The agreed CSFs for the proposed investment in additional regional forensic psychiatric capacity are summarised in Table 17.

Table 17: Critical Success Factors

Critical Success Factor
<p>Strategic fit and business needs</p> <p>How well the option meets the agreed IOs, related business needs and service requirements, and integrates with other strategies, programmes and projects.</p>
<p>Potential Value for Money</p> <p>How well the option optimises value for money (i.e. the optimal mix of potential benefits, costs and risks).</p>
<p>Supplier capacity and capability</p> <p>How well the option matches the ability of potential suppliers to deliver the required services, and is likely to result in a sustainable arrangement that optimises value for money.</p>
<p>Potential affordability</p> <p>How well the option can be met from likely available funding, and matches other funding constraints.</p>
<p>Potential achievability</p> <p>How well the option is likely to be delivered given the organisations ability to respond to the changes required, and matches the level of available skills required for successful delivery.</p>

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7. Options Analysis

A limited options analysis was undertaken for this business case, as this business case aligns with and flows from the earlier (2012) business case, for which a comprehensive options analysis was undertaken. It is important to note that the circumstances have changed since the options analysis was undertaken for the 2012 business case. At that time, the option of a new build on site was rejected, as was the ongoing utilisation of additional capacity from new build on site¹⁰:

“Complex decanting process would not be easy to implement. The cost is higher than for other options and it is not considered to be affordable within the funding currently identified. The requirement for demolition/removal of existing buildings would lengthen the overall timescale.”

“Additional capacity would meet expected future service demand requirements, but it would not be affordable to build or continue to run a new facility.”

With the confirmation from the Ministry of Health in late 2014 that additional funds would be forthcoming for the planned 15 additional beds, the development of a permanent facility for additional capacity became feasible. This has permitted a re-evaluation of previously considered and rejected options. The options considered specifically for the additional capacity, revisited for this business case, are summarised in Table 18. The full analysis is attached as Appendix 6.

Table 18: Options for Additional Capacity

Option Dimension	Options Considered	Assessment	Conclusion
Service Solution	10 beds	<ul style="list-style-type: none"> Insufficient capacity to meet projected demand Capacity would be inadequate to enable decanting/remediation 	No
	15 beds	<ul style="list-style-type: none"> Sized to meet projected demand, based on known population and prison growth 	Preferred
	On site – extension of existing facilities	<ul style="list-style-type: none"> Insufficient capacity to meet projected demand Capacity would be inadequate to enable decanting/remediation 	No
	On site – new build	<ul style="list-style-type: none"> Proximity to existing services Aligns with vision Would support achievement of Remedial Works project Aligns with long term site plan 	Preferred
	Off site – new build	<ul style="list-style-type: none"> Sized to meet projected demand, based on known population and prison growth Would support decant/remediation No location identified, therefore feasibility unknown 	Possible
	Temporary capacity	<ul style="list-style-type: none"> Insufficient capacity to meet projected demand in the long term 	No
	Permanent capacity	<ul style="list-style-type: none"> Would provide capacity to meet projected demand in the long term 	Preferred

¹⁰ Strategic Stage Analysis Case Mason Clinic: Critical Improvements to Forensic Mental Health Services (Facilities and Capacity) 6 June 2012

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Service Delivery Options	In-house	<ul style="list-style-type: none"> Aligns with service vision 	Preferred
	Retain CCDHB capacity long-term	<ul style="list-style-type: none"> Does not meet requirement for local provision of services 	No
	Outsource to another provider	<ul style="list-style-type: none"> Does not meet requirement for local provision of services No other provider identified with capacity or capability 	No

The options are summarised as:

- Option 1: Do Nothing
- Option 2: 15 bed permanent build, offsite
- Option 3: 15 bed permanent build, onsite

The preferred option is **Option 3**. This meets the Intermediate Scope requirements, outlined in Section 4.2.

8. Project Costs

The capital cost for this project is \$14.443m, as itemised in Table 19. This figure is the initial capital cost of the build and excludes both ongoing maintenance and additional investment which would be required over the life of the facility (e.g. replacement furniture, fixtures and equipment (FF&E), IT etc.).

Table 19: Project Capital Costs¹¹

Description of Cost	\$
Unit build with GFA of 1772m ²	9,757,000
Demolition	127,000
Infrastructure	500,000
Fees and consents	1,746,000
FF&E	500,000
IT (Health Alliance)	500,000
Contingency	1,313,000
Total Project Cost	14,443,000

9. Project Financing

The Board approved \$9.8m for this facility in 2014. The revised estimated capital cost of the new facility is \$14.443m. It is proposed that the additional \$4.643m is funded from WDHB cash reserves.

¹¹ Capital Cost estimate was prepared by independent Quantity Surveyors Rider Levett Bucknall, May 2015. (Refer Appendix 7). The QS estimate has been amended for additional contingency provision (revised from \$1m to \$1.313m) and \$30k added to build cost for in house project manager.

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10. Financial Analysis and Affordability

10.1 Financial Analysis Overview

The capital cost of the proposed investment is \$14.443m. The financial modelling of the 15-bed Medium Secure Unit generates:

- A negative NPV \$1.0m. A negative NPV suggests that costs are greater than financial benefits over the project duration;
- A projected profit and loss which is favourable from 2025 onwards, due to additional demographic funding made available to operationalize the 15 beds on completion of remedial works;
- The net book value of the building would be \$12.4m on completion of the remedial works

10.2 Key Financial Assumptions

The key financial assumptions for the proposed investment in additional regional forensic psychiatric capacity are summarised in Table 20.

Table 20: Key Financial Assumptions

Assumption	Summary
Capital Expenditure	The total project capex cost used in this analysis is \$14.4 as per Table 19.
Depreciation Rates	Depreciation rate for building is 4% (25 years life). Depreciation rate for FF&E is 10% Depreciation rate for IT infrastructure is 6.6%
Discount Rate – Net Present Value	The discount rate applied in the Net Present Value analysis is 8% per NZ Treasury/National Health Board guidelines.
Opportunity Cost of Capital	It is proposed that this project is funded by WDHB cash, therefore there is an opportunity cost of capital as the cash could have alternatively been used to (i) repay debt, (ii) repay equity, or (iii) invest on money market instruments and earn interest income. The rate applied in the P&L is 8%
FF&E & IT	It is assumed that replacement of FF&E and IT will be achieved via the BAU annual Capital bids request process
Revenue	Revenue to increase at 1% pa from 21/22 year, as prior years are contracted for a fixed rate.
Demographic Growth	Consist of ASCF and High & Complex Needs beds
Staffing Cost	Staffing cost to increase at 1% pa from 21/22.
Repairs & Maintenance	Provision for approx. 2.5-3% of capital cost for repairs & maintenance after defects liability period expiry.
Non Payroll Cost	Clinical supplies, hotel services, cleaning is budgeted for contracted service delivery growth and to remain constant.

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10.3 Financial Projections

The Profit and Loss statement for the 15 bed medium secure unit shows:

- Demographic revenue and costs, including the remedial works period (2015-2020). The rationale for this inclusion being additional revenue which is dependent upon the 15 Bed medium secure unit build.
- Additional bed capacity will initially be realised in existing units as the new unit will not be available until 2020.
- Revenue is split into two categories:
 - Demographic consisting 5 beds Auckland South Corrections Facility (ASCF) and 5 beds high and complex mental health needs. The additional beds are scheduled to open as follows:
 - 3 beds 2015/16 - High & Complex (utilising existing capacity in inpatient units Tanekaha and Tane Whakapiripiri)
 - 2 Beds 2016/17 - High & Complex (utilising existing capacity in inpatient unit Kahikatea)
 - 3 beds 2017/18 – ASCF (utilising capacity within new building during remedial works)
 - 2 beds 2020/21 – ASCF (new building)
 - Repatriation of 5 Beds (along with funding) from Capital & Coast DHB expected in 2020
- The FTE numbers align with the agreed contracted service delivery, as per MOH letter dated 4 November 2014 addressing bed pressures at the Mason Clinic.
- Assumption that demographic funding will continue as “business as usual” from 2020 onwards, given the substantial resource investment e.g. personnel etc.

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Profit & Loss Statement

The Profit and Loss Statement for the proposed investment is detailed in Table 21.

Table 21: Profit and Loss Statement
\$000

Cost of Capital Project Life Years	8% 25	Initial Investment	Years					Total
			1-5	6-10	11-15	16-20	21-25	
Financial Year			2015-20	2020-25	2025-30	2030-35	2035-40	
Investment								
Buildings & Plant		0	-13,403					-13,403
Other Equipment - FF&E		0	-500		0		0	-500
IT (HealthA)		0	-500			0		-500
Signage		0	-10					-10
Decanting Puriri Facility		0	-30					-30
Total Investment Outflow		0	-14,443	0	0	0	0	-14,443
Revenue								
Demographic revenue			12,937	18,751	19,708	20,713	21,770	93,879
CCDHB - Repatriated Beds			825	8,417	8,846	9,297	9,771	37,156
Total Revenue			13,762	27,168	28,554	30,010	31,541	131,035
Expenditure								
Personnel								
Medical			-942	-2,048	-2,177	-2,288	-2,404	-9,859
Nursing			-7,224	-15,687	-16,674	-17,525	-18,419	-75,529
Allied			-296	-647	-688	-723	-760	-3,113
Support			-42	-434	-456	-479	-503	-1,914
Admin			-64	-141	-150	-158	-166	-679
Non Payroll Costs								
Clinical Supplies			-53	-110	-110	-110	-110	-493
Hotel Services/Laundry/Cleaning			-26	-265	-265	-265	-265	-1,086
R&M			-600	-2,000	-2,000	-2,000	-2,000	-8,600
Opportunity cost of capital			-4,631	-4,201	-2,987	-1,864	-790	-14,473
Depreciation			-2,053	-3,096	-2,946	-2,735	-2,681	-13,510
Total Expenditure		0	-15,931	-28,628	-28,452	-28,146	-28,098	-129,255
Net Profit / (Loss)			-2,169	-1,460	102	1,864	3,443	1,780

Table 20a: FTEs

Years	YEARS								
	15/16	16/17	17/18	18/19	19/20		20/21		2021/22 Onwards
					Jul-Dec	Jan-Jun	Jul-Dec	Jan-Jun	
Medical	0.5	0.8	1.3	1.3	1.3	2.2	2.2	2.5	2.5
Nursing	4.4	7.3	11.7	11.7	11.7	19.1	19.1	22.0	22.0
Allied	3.5	5.8	9.2	9.2	9.2	15.0	15.0	17.3	17.3
Cultural	0.4	0.7	1.1	1.1	1.1	1.7	1.7	2.0	2.0
Support	0.0	0.0	0.0	0.0	0.0	2.0	2.0	2.0	2.0
Admin	0.1	0.2	0.3	0.3	0.3	0.4	0.4	0.5	0.5
Total	8.9	14.8	23.6	23.6	23.6	40.4	40.4	46.3	46.3

Note1: 5 beds will be repatriated from CCDHB in Jan 2020 and therefore the additional staff in 19/20 will be recruited at that date

Note2: Additional staff in 20/21 will be recruited to from Jan 2021 as the 2 additional beds will not be opened until then

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Net Present Value Statement

The Net Present Value Statement for the proposed investment is detailed in Table 22.

Table 22: Net Present Value Statement

\$000

Discount Rate Project Life Years Financial Year	8% 25 Initial Investment	Years				
		1-5	6-10	11-15	16-20	21-25
		2015-20	2020-25	2025-30	2030-35	2035-40
Investment						
Buildings & Plant	0	-13,403				
Other Equipment - FF & E	0	-500				
IT (HealthA)	0	-500				
Signage	0	-10				
Decanting Puriri Facility	0	-30				
Total Investment Outflow	0	-14,443	0	0	0	0
Demographic Beds		12,937	18,751	19,708	20,713	21,770
CCDHB - Repatriated Beds		825	8,417	8,846	9,297	9,771
Total Inflows		13,762	27,168	28,554	30,010	31,541
Medical		-942	-2,048	-2,177	-2,288	-2,404
Nursing		-7,224	-15,687	-16,674	-17,525	-18,419
Allied		-296	-647	-688	-723	-760
Support		-42	-434	-456	-479	-503
Admin		-64	-141	-150	-158	-166
Clinical Supplies		-53	-110	-110	-110	-110
Hotel Services/Laundry/Cleaning		-26	-265	-265	-265	-265
R&M		-600	-2,000	-2,000	-2,000	-2,000
Total Expenditure	0	-9,247	-21,332	-22,520	-23,547	-24,627
Operating Cash Inflows/-Outflows	0	4,515	5,836	6,034	6,463	6,914
Net Cashflow	0	-9,928	5,836	6,034	6,463	6,914
Cumulative Cashflow	0	-9,928	-4,092	1,943	8,406	15,319
Investment Evaluation						
Net Present Value		-1,045		Non-discounted Cash Payback		
Internal Rate of Return		7.03%		13.43 Years		

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11. Project Assumptions, Constraints and Dependencies

The key project assumptions, dependencies¹² and constraints¹³ identified for this investment are shown in Table 23.

Table 23: Key Assumptions, Dependencies and Constraints

Assumptions	Summary
There will be no significant changes in patterns of activity	Existing patterns of demand are expected to continue. Growth matches projected demand, from prisons, population growth and repatriation of out of area patients.
Services maintained during build and Remedial Works project	Clinical services must continue to be provided, safely, during the build and any decanting required for the associated Remedial Works project. Administrative services would need to be maintained throughout.
Unitary Plan does not impact service plans	The Unitary Plan does not impact on the service plans for the establishment of the new 15-bedded unit
Dependencies	Summary
Adequate car parking	This is a critical dependency (see Section 2.3). If car parking is not adequately resolved (all other things being equal), the additional capacity proposed in this business case cannot be utilised.
Adequate administrative accommodation	Permanent accommodation will be required for staff decanting from Puriri (temporarily housed in clinical space during the build) and for additional staff required for the increased capacity
Constraints	Summary
Capital budget	The capital funding available is constrained by other pressures on WDHB capital budget. Whilst no new equity is sought, the investment must be affordable within the allocated budget.
Operational budget	The operational funding available is constrained by other pressures on WDHB operational budget. The ongoing operational impact of the capital investment must be affordable within the overall WDHB funding allocation. This includes the funding for the additional capacity (15 beds) approved by Ministry of Health, November 2014.
Facility timeline to opening	The decant facility is expected to be operational by February 2017, to enable decanting to commence.

¹² "Any actions or developments required of others and outside the scope of the project or programme, if the ultimate success of the investment proposal is dependent upon them". Better Business Cases for Capital Proposals, July 2011.

¹³ "Limiting parameters within which the investment must be delivered". Better Business Cases for Capital Proposals, July 2011.

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12. Risk Analysis and Management

The project risks have been identified and recorded in the Project Risk Register. A summary of the most critical risks and issues is attached as Appendix 8. Detailed risk management planning is ongoing and would be continued during the detailed planning and implementation phases of this project. The risks assessed as being the highest probability and highest impact for the success of the project are summarised in Table 24.

Table 24: Key Project Risks

Key Risks	Risk Management Approach
Car parking solution is not approved, preventing additional capacity from being utilised. This would prevent repatriation of patients from CCDHB and would drive an increase in waiting times. However, there are a number of unresolved issues that could mitigate the need for a car park.	Development of the business case and resolution of issues/identification of an acceptable solution prior to completion of the remedial works programme. Internal review of investment priorities. Ongoing communication with Council.
Client scope change increases design/build timeline, cost or both. This would delay decanting, impacting the Remedial Works project timeline. Delay in opening additional permanent capacity to reduce waiting times and enable repatriation of patients from CCDHB.	Strong Project Manager control. Escalation process for change requests, requiring cost and project impact assessment prior to approval
Delay in receiving approvals results in an extended timeline, impacting ability to commence and complete decanting. Delay in opening additional permanent capacity to reduce waiting times and enable repatriation of patients from CCDHB.	Strong project manager control. Escalation process for change requests, requiring cost and project impact assessment prior to approval.
Time to build exceeds expected timeline, impacting ability to commence and complete decanting as well as delaying opening of additional capacity to reduce waiting times and enable repatriation of patients from CCDHB.	Planning and design is underway, prior to receiving approvals. Strong project management and penalties for the builders for delays in completion.

Standard commercial risks and issues methodologies would be used to assure stakeholders, Sponsor and monitoring agencies that the project team was proactively identifying and mitigating risks.

The Risks and Issues Register would be a living document and would be updated continually to reflect the current status of any risks and issues arising. All key risks and issues would be reported, monitored and escalated as appropriate. Risks and Issues would be reviewed regularly to identify any areas that would impact on project deliverables and/or the project timeline.

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13. Project Implementation

13.1 Implementation Plan

Project Management

WDHB has a successful track record in delivering health facility projects and would use established processes and procedures to guide the project team. This would ensure appropriate oversight of key decisions, including approval to proceed. These procedures include:

1. Change Control Procedures
2. Document Control
3. Monthly Reporting Processes
4. Issues Resolution
5. Construction Management Plan
6. Information & Communications Management
7. Quality Management Plan
8. Cost Management
9. Time Scheduling

A draft project execution plan has been developed to support the above processes and would be further developed and implemented in the next phase.

The Project Sponsor would determine the tolerances for project manager and implementation team. This would enable the project sufficient leeway to make local decisions without referring upwards for minor variances. If the agreed project tolerances are agreed, or are forecast to be exceeded, an exception report would be produced. Variances would be escalated to the Project Sponsor, and further to the Chief Executive if required, to ensure that control was maintained over the project as it progresses.

The build elements of the project would be managed by an experienced facilities manager. The overall project and change management would be managed by a dedicated Project Manager and will follow the Prince2 methodology.

Procurement

The procurement approach for this investment would follow the standard New Zealand government procurement policy¹⁴. This includes ensuring best value for money over the whole of life, and having open and effective competition with full and fair opportunity for domestic suppliers.

Based on the recommended preferred option, the proposed procurement approach is to select and appoint contractors for the building of the 15-bedded unit.

The risk sharing approach and contract provisions for these services have not been determined at this stage, and would be negotiated with the provider(s) as part of the appointment process.

¹⁴ See <http://www.business.govt.nz/procurement> for more detail.

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13.2 Implementation Timeline

The key project milestones and indicative dates are shown in Table 25.

Table 25: Key Project Milestones and Indicative Dates

Key Milestones	End Date
Business Case approval	Jul - Sep 2015
Design	Feb - Dec 2015
Tender	Oct 15 – Jan 16
Building consent	Dec 15 – Feb 16
Construction	Feb 16 – Jan 17
Commissioning	Jan - Feb 2017
Facility operational	Feb 17

The facility would be operational from February 2017, to accommodate the first decanted patients as part of the remediation works. The first move would be patients from Tanekaha. Once work on that unit was complete, patients from the Rata unit would be moved into the new facility. It is anticipated that the Rata patients would remain in the new unit until completion of the remediation works. The new facility would be designed for medium secure patients, and would therefore be appropriate for the Rata patients. The remaining patients, including the higher security patients, would be decanted through Rata to ensure security throughout the remediation works.

13.3 Stakeholder Engagement

The key internal and external stakeholders have been identified and are summarised in Figure 4. Approaches to communications and engagement throughout the development of this business case, and planned for the implementation phase, have been determined based on the degree of impact the project would have on each stakeholder/stakeholder group.

Stakeholder engagement has been a key component of the project to date. Engagement has varied between stakeholder groups, to meet the needs of that specific group.

Users have participated through focus groups on design and have been kept updated through the Mason Magazine. Cultural staff have been engaged in ensuring that the requirements meet cultural needs through engagement in design and planning meetings. Administrative staff have been kept informed through meetings and newsletters, clinical staff have been consulted on the design process and staff facility requirements. Regular meetings have been held with CCDHB to provide updates on planning and expected timelines. There have been meetings with the Unions, who receive monthly updates and newsletters. Unitec has been engaged, primarily regarding the sale or lease of land. Regional partners (the other three Northern Region DHBs) have been engaged through regional services planning. The Board, Treasury and Ministry of Health have received updates and briefings as the planning has progressed.

Communication and engagement would be a critical element of the project planning and execution. The communications plan would be refined during the detailed planning and implementation phase. For the key players there would be a continued focus on forums and meetings, supported by written materials

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(newsletters etc.). For the Active Consultation Group, it is intended that some engagement would be through meetings, but with a stronger emphasis on other communication methods, e.g. newsletters. Limited resource would mean that communication with the less impacted/influential stakeholders would be primarily through written means; newsletters and updates. The detailed communications plan for this project is available on request from the Project team.

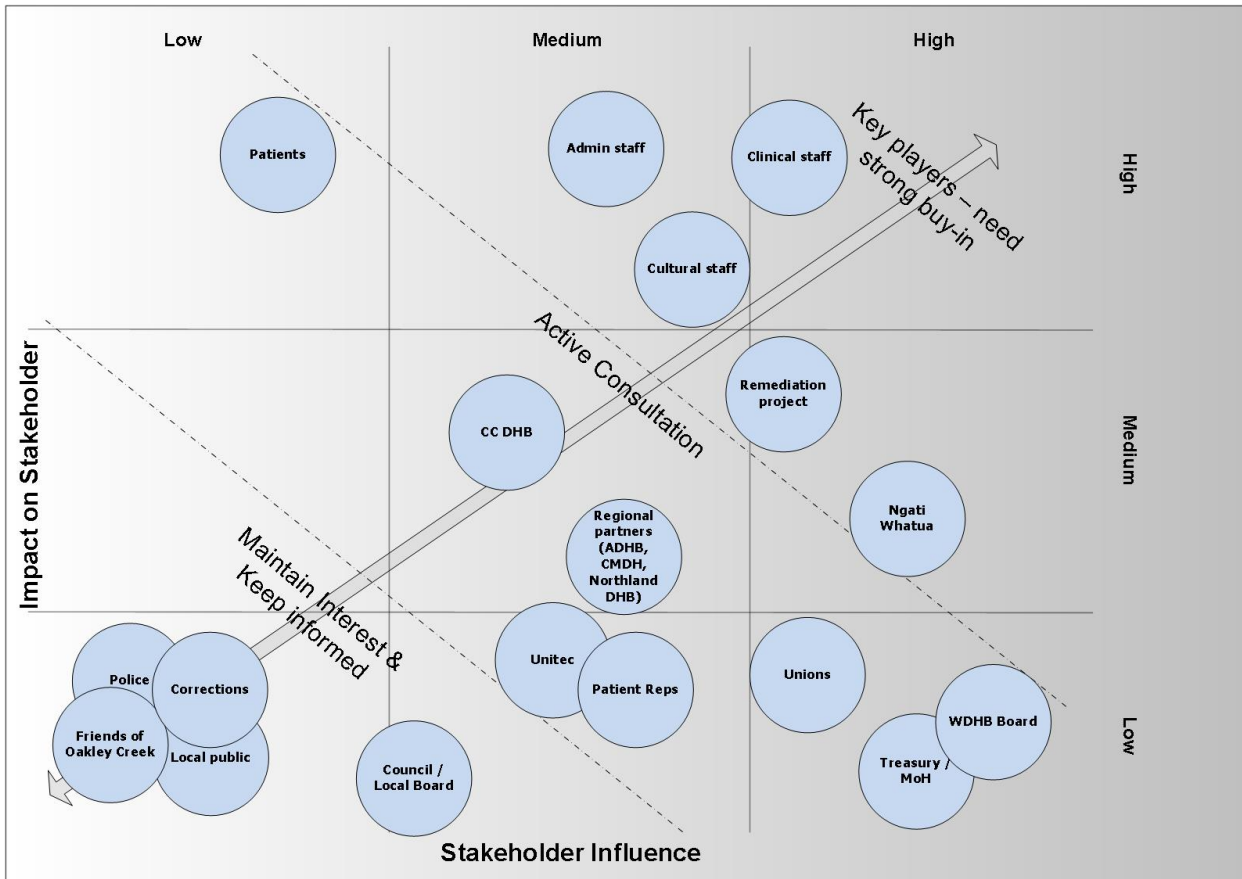


Figure 4: Key Stakeholders

13.4 Change Management

Limited change management would be required for the proposed investment in additional capacity. The most impacted stakeholders (staff and patients) would continue to provide, and receive, fundamentally the same service and care as under current arrangements, but in a different setting.

The most significant change management will relate to the associated Remedial Works project. Change management planning will be undertaken for that project, and will be utilised where required when the projects overlap. All relevant stakeholders (patients from Tanekaha and Rata units and their representatives, administrative and clinical staff) would be informed of the proposed migration to the new unit. Initial discussions have occurred with affected staff on the indicative timeline and impact of the proposed move.

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13.5 Project Structure, Monitoring and Reporting

Project Structure

The Mason Clinic Project governance structure follows similar approaches to other major redevelopment projects undertaken by WDHB. This includes a Project Steering Group that is already in place and comprises Forensic Services clinical staff, management staff, Finance, Facilities and with a WDHB Executive Leadership member, the Chief Financial Officer (CFO) and Mental Health General Manager as the sponsor of the project. The proposed project structure showing the reporting arrangements is depicted in Figure 5.

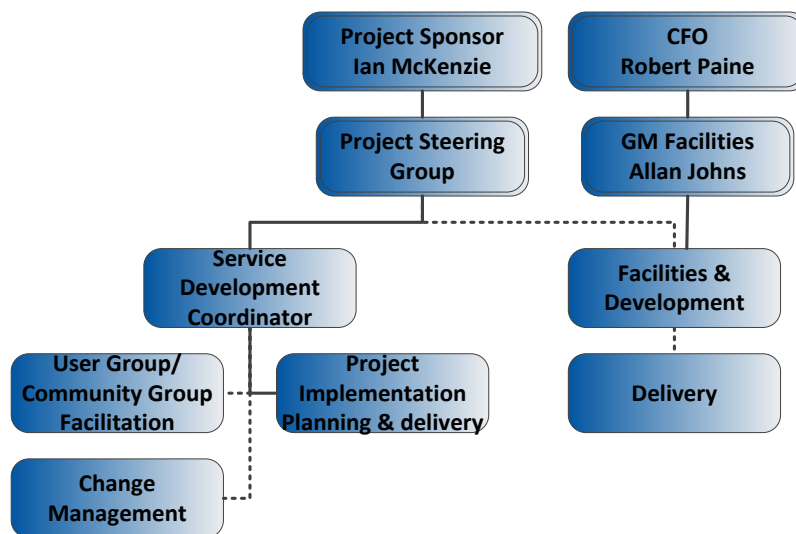


Figure 5: Project Organisation Chart

The Steering Group membership is:

- General Manager – Ian McKenzie (Project Sponsor)
- Clinical Director Forensic Mental Health – Jeremy Skipworth
- Chief Financial Officer – Robert Paine
- Consumer Consultant Mental Health Group – Ana Sokratov
- General Manager, Facilities and Development – Allan Johns
- Service Development Forensic Mental Health Service – Pam Lightbown
- Project Manager – Paul Stanbridge
- Project Manager/Associate Service Manager – Bruce Talbot
- Financial Lead – Steven Yee
- Associate Service Manager – Claire McCarten
- Associate Service Manager – Neville Thomson

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Monitoring

The project would be subject to standard WDHB internal monitoring and review. As the project has been assessed as “Medium” on the NZ Treasury Risk Profile Assessment, there is no requirement for Major Project Assurance or Gateway review.

The identification, measurement and tracking of benefits would be undertaken to ensure that the expected outcomes are realised. The Project Sponsor would have overall responsibility for the realisation of benefits. Monitoring and delivery of benefits would be the responsibility of the Service Manager.

A detailed benefits register would be created and maintained by the project manager for the duration of the project, with post-project responsibility reverting to the Service Manager

Reporting

A monthly update report would be provided by the Project Sponsor to the Chief Executive on project progress, i.e. if the project is on time, on budget and able to achieve the objectives of the business case. Progress reporting would also be made to the National Health Board, at agreed key milestone points.

13.6 Post Implementation Evaluation

Project Evaluation: This would take place within one month of project completion. It would confirm the extent to which deliverables have been completed and would reconcile the project budget and timelines to plan. This review would also consider lessons learned and would identify the extent to which the expected benefits have been realised at that point.

Post Project Review: This would take place within 12 months of project go-live. The review would assess the benefits realised compared to the business case, identify new benefits realised but not claimed in the business case, and include planning for ongoing improvements in performance. This review would provide assurance to the DHB that the project has delivered the anticipated benefits, or is on track to do so.

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14. Conclusion and Recommendation

14.1 Conclusion

The Mason Clinic is beyond capacity and demand is increasing. Patients waiting for admission for acute and sub-acute inpatient care are being held in inappropriate facilities. Since 2013, patients have been transferred out of area as the lack of capacity has prevented timely and appropriate access to services. Excessive waiting times are impacting the quality of patient care, resulting in patient health deteriorating, increasing costs associated with increased acuity and, ultimately, poorer health outcomes.

Demand will continue to grow, with the additional demand from growth in prison muster and population growth, driving an increase in the number of people with high and complex mental health needs.

At the same time as demand is increasing, the existing Mason Clinic buildings require urgent major remedial works to resolve significant weather-tightness issues. In the absence of a permanent facility, temporary decanting capacity would be required at an estimated cost of \$4.2m.

By investing in a permanent facility, WDHB would create a facility which can meet both the temporary need to enable decanting and remediation of existing facilities, and provide capacity for the known increase in demand which cannot currently be met.

14.2 Recommendation

The capital cost of the proposed facility is \$14.443m. The Board approved \$9.8m for this investment in July 2014.

It is recommended:

That the Board:

- Endorse the Business Case for presentation at the September meeting of the Capital Investment Committee.
- Note that this is a refresh of the Business case endorsed by Waitemata DHB in July 2014
- Note the paper Mason Clinic Leaky Buildings Remediation and Repair Work Programme (previous agenda item) will be appended to the Business Case as a context paper
- Approve the uplift in budget to \$14.443m for the construction of the 15 bed inpatient unit, funded from cash reserves and enhanced additional Ministry of Health revenue for increased forensic demand.

Mason Clinic – Increasing Regional Forensic Psychiatric Capacity

Appendix 1: Summary of Changes in Facility Size

Board Committee - Information Paper

Mason Clinic – 15 Bed Medium Secure Unit

Recommendation:

That the Board:

1. approves that a single staged business case be prepared and submitted to the Board for approval in August 2015 and to the Capital Investment Committee in September 2015
2. notes an increased GFA from 1600m² to 1772m² and increased project cost from \$9.8M to \$14.443M for the 15 Bed Medium Secure Unit at the Mason Clinic
3. notes that the detailed design for the unit will proceed while approval for the revised project scope is sought.

Prepared by: Paul Stanbridge (Project Manager, Facilities and Development Project Office)

Endorsed by: Ian McKenzie (General Manager, Mental Health Services)

Allan Johns (General Manager, Facilities and Development)

Robert Paine (Chief Financial Officer and Head of Corporate Services)

Glossary

CIC Capital Investment Committee

FFE Furniture, Fittings and Equipment

GFA Gross Floor Area

MoH Ministry of Health

• Executive Summary

In August 2014 the Board approved the construction of a 15 Bed Medium Secure Unit at the Mason Clinic incorporating the MoH request to include five additional beds for the repatriation of patients from Capital and Coast.

The project had a budget of \$9.8M which was based on a conceptual GFA estimation of 1600m².

Since this date, the design has been developed following a detailed review of the proposed site and value engineering workshops with WDHB staff.

This has resulted in a design with a GFA of 1772m², an increase of 172 m², which is the smallest compliant footprint that can be achieved without adversely impacting on service delivery.

The revised cost of the project has increased from \$9.8M to \$14.443M. This has been reviewed by an independent Quantity Surveyor.

As the project value now exceeds \$10M it requires approval from the CIC.

Mason Clinic – Increasing Regional Forensic Psychiatric Capacity

The Board will remember that the additional beds will be used in the first instance as a decanting facility to enable a number of upgrades to leaky buildings on the campus.

Since delays to this project will result in further deterioration of the leaky buildings, which increases the risks to health and safety of staff and patients, it is also proposed the development of the detailed design progresses while this approval is sought.

Given the urgency for this facility and the MoH's prior awareness of this case it is proposed that a Single Staged Business Case be prepared and submitted to the WDHB Board in August 2015 and to the CIC in September 2015, however this must be confirmed with CIC.

- **Introduction/Background**

A number of the buildings at the Mason Clinic are in very poor condition, some of which are leaky buildings. This presents a significant risk to the health and safety of patients and staff.

Each year the facilities are not remediated, the condition deteriorates and the health and safety risk increases.

A programme to remediate these buildings has been developed, however construction of a decant facility is initially required to allow buildings to be vacated during the rehabilitation works.

The design and construction of this facility was programmed to be completed and commissioned by January 2017 with the remediation and repair of the other facilities at Mason Clinic to be carried out over the following five years.

At the end of this period, the decant unit will form part of the Kaupapa Maori Service delivery.

It was proposed that a 10 bed unit would be constructed for the decanting, however during the development of this case the MoH requested the scope be increased to 15 beds to provide five additional beds for the repatriation of patients from Capital and Coast.

The development of the 15 bed unit was approved by the Board in August 2014 with a budget of \$9.8M based on a GFA estimation of 1600m².

- **Developments to date**

Since the Board approval, the concept design has been developed. This included a detailed review of the proposed site of the unit and value engineering workshops with WDHB staff.

The proposed site has three large English Plain trees. In the original business case it was considered that that these trees would need to be retained however, it has been identified that this they can be removed.

A number of other requirements and changes have taken place since the approval of the original business case. These have been taken into account and the design has been revised accordingly. This included a value engineering workshop by the project group to ensure that revisions were minimal while ensuring regulatory compliance and without adversely impacting on service delivery.

The revised design increases the original GFA by 172m² from 1600m² to 1772m².

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Item	Original business case	New business case	Overall Increase	Comments
Increasing the size of the 15 bedrooms	135m ² (9m ² per room)	180m ² (12m ² per room)	45m ² total	9m ² was originally proposed to stay within the available GFA and align with existing Mason Clinic facilities. However, these were designed prior to the changes to the Australasian Health Facility Guidelines which has bedroom size of 12m ² . It is proposed to increase the bedroom size to meet the guidelines which aligns with the design of the new He Puna Waiora facility.
Providing an facility for women to bedroom and living areas and have access to their own courtyard	Not included	14m ²	14m ²	The service user group identified this requirement due to the increase in female patients and the associated increased health and safety risk.
Increased plant and equipment area	23m ²	115m ²	92m ²	To provide suitable space for safe operation and maintenance. This is based on the He Puna Waiora model of minimising maintenance impact on clinical space, which was developed after the original Mason Clinic business case. This also includes 15m ² for an IT hub room.
An additional stair well and lift access	35m ²	56m ²	21m ²	The removal of the existing Puriri Building on the site of the 15 bed unit means office staff require relocation. There is a lack of office space within the Mason Clinic and the cost to build additional buildings is significant. To mitigate this, the design has incorporated additional office space within the upper floor. However, this requires an additional stairwell and lift to meet the building compliance code. This is based on providing two means of escape and a lift for disabled access requirements.
	193m ²	365m ²	172m ²	

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The cost of the revised design has been assessed at \$14.443M. The majority of which is due to financial escalation since the case was approved. The revised cost includes escalation allowance for a 12 month period to allow CIC approval prior to commencement of the project. This has been reviewed by an independent Quantity Surveyor.

As the revised cost of the project exceeds \$10M, it will require approval from the Board and from the CIC.

• **Way Forward**

The normal process for projects requiring CIC approval is to submit a strategic business case followed by an indicative business case and finally a detailed business case. This is a lengthy process.

As delays to this project will increase the risk to health and safety of patients and staff and since the MoH have prior knowledge of this case it is proposed that a single stage business case is developed and submitted to the CIC in August 2015, following submission to the Board in July 2015.

A meeting with representatives of the MoH and CIC will be held in June 2015 to confirm this is an acceptable approach.

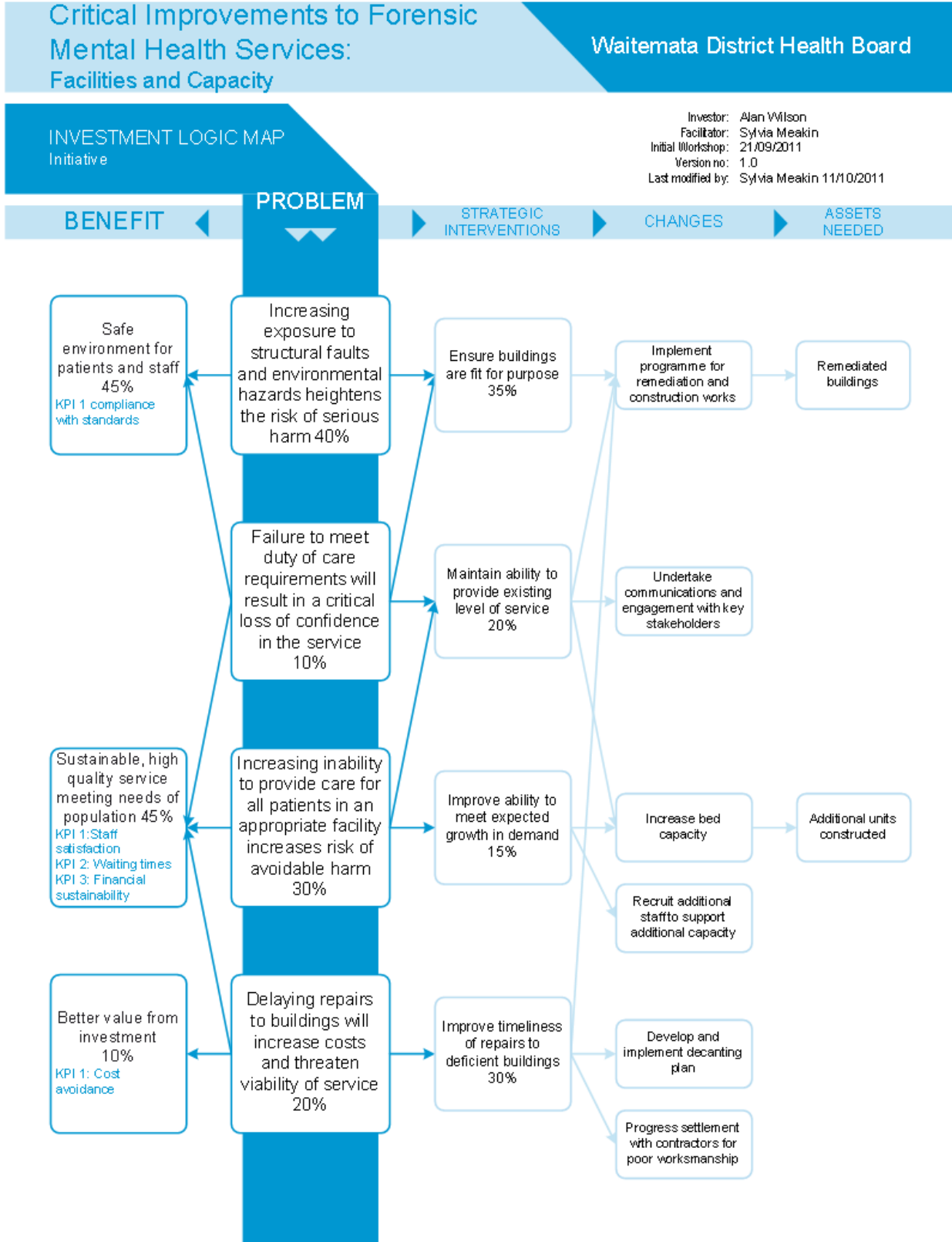
Given the risk to the health and safety of patients and staff, the Chief Financial Officer has requested that while approval is being sought the development of the detailed design continues, within the approved budget.

The programme for the delivery of the 15 bed unit is as follows:

- Commence detail design June 2015
- Seek Board approval for uplift August 2015
- Obtain Resource Consent on going 2015
- Submit single stage business case to CIC September 2015
- Issue Design for Tender December 2015
- Commence construction January 2016
- Facility complete January 2017

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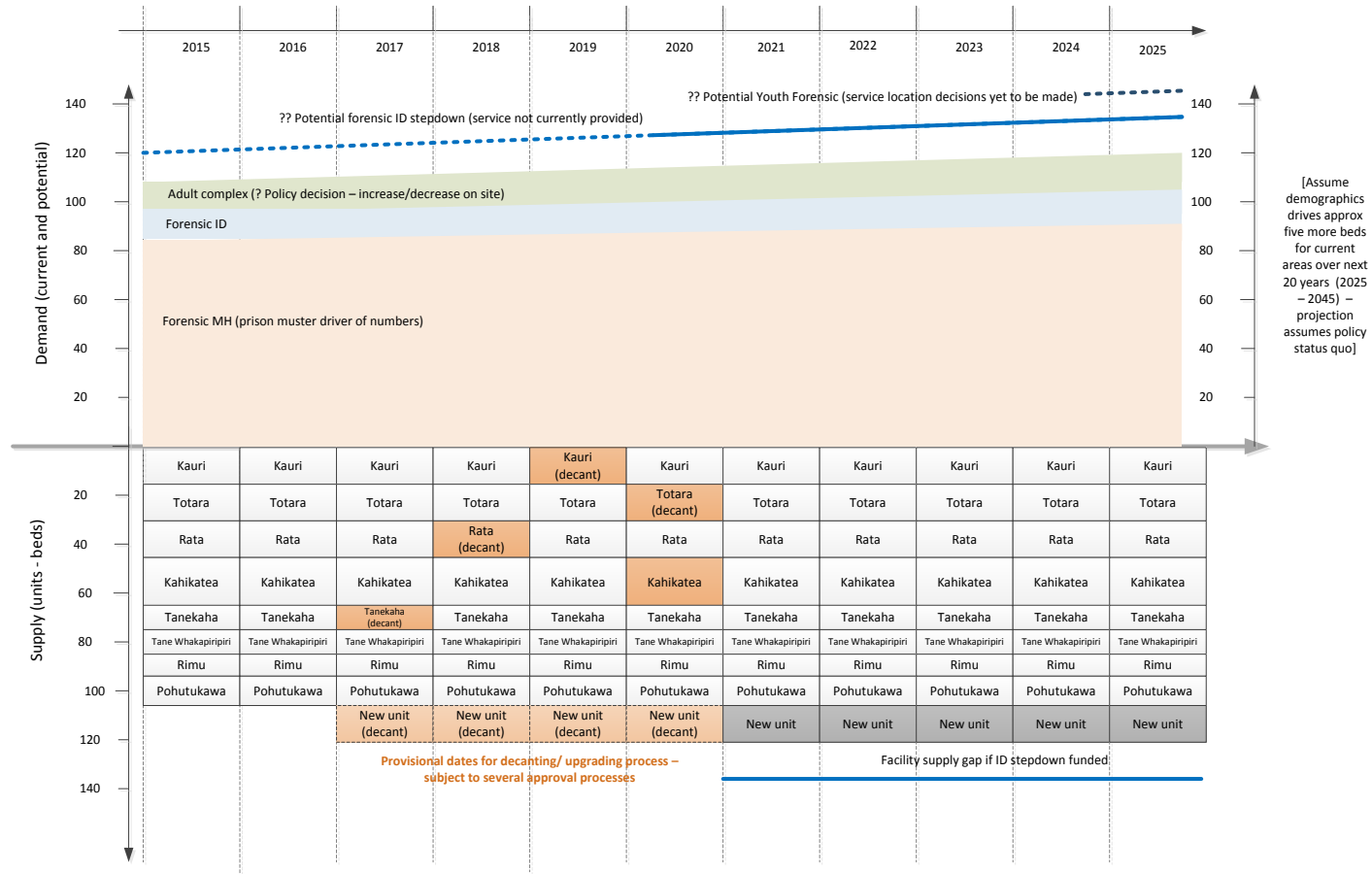
Appendix 2: 2011 Investment Logic Map (Facilities and Capacity)



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Appendix 3: Summary of 10 Year Projections of Supply and Demand for Mason Clinic Facilities¹⁵

Summary of 10 year projections of supply and demand for Mason Clinic facilities



¹⁵ Source: Synergia Ltd July 2015

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Appendix 4: Mason Clinic Overall Master Site Plan

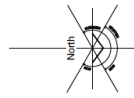


A 10/07/14 JG 04/07/15/16/17/18/19/20/21/22/23/24/25/26/27/28/29/30/31/32/33/34/35/36/37/38/39/40/41/42/43/44/45/46/47/48/49/50/51/52/53/54/55/56/57/58/59/60/61/62/63/64/65/66/67/68/69/70/71/72/73/74/75/76/77/78/79/80/81/82/83/84/85/86/87/88/89/90/91/92/93/94/95/96/97/98/99/100
 REVISIONS DATE BY REASON
Klein
 PO Box 101, Teesdale Way, PO Box 101, Auckland
 Phone: 09 277 1000 Fax: 09 277 1000
 www.klein.co.nz Email: sales@klein.co.nz
MASON CLINIC OVERALL MASTER SITE PLAN
 Unitahia, Cape 2, Chatterton Road, Pt Chev
 For Waitemata District Health Board
 Drawing No: **EXISTING SITE AERIAL**
 Drawn: JG Checked: JG
 Date: 04/07/14
 Scale: 1:500 @ A1 (1:1000 @ A0)
 Job No: Drawing No: Revision:
3.1074 CD-000 A
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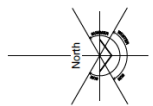
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 REVISIONS DATE BY REASON
Klein
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 Drawn: JG Checked: JG
 Date: 04/07/14
 Scale: 1:500 @ A1 (1:1000 @ A0)
 Job No: Drawing No: Revision:
3.1074 CD-001 A
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REVISIONS	DATE	BY	REASON
Klein Limited 27 College Hill, Parnassia Bay Phone: 09 077 1000 Fax: 09 077 1000 Email: sales@kcln.co.nz			
MASON CLINIC OVERALL MASTER SITE PLAN Unibach, Gate 2, Carrington Road, Pt Chev For: HORTON AND PARTNERS CONSULTANTS			
Drawing Title			
Overall Master Site Plan			
Option 1			
Drawn	JS	Checked	NR
Date	JULY 2014		
Client	eg CD000		
Scale	1:500 @ A1 / 1:1000 @ A0		
Job No.	3.1074	Drawing No.	CD-002
		Revision:	A

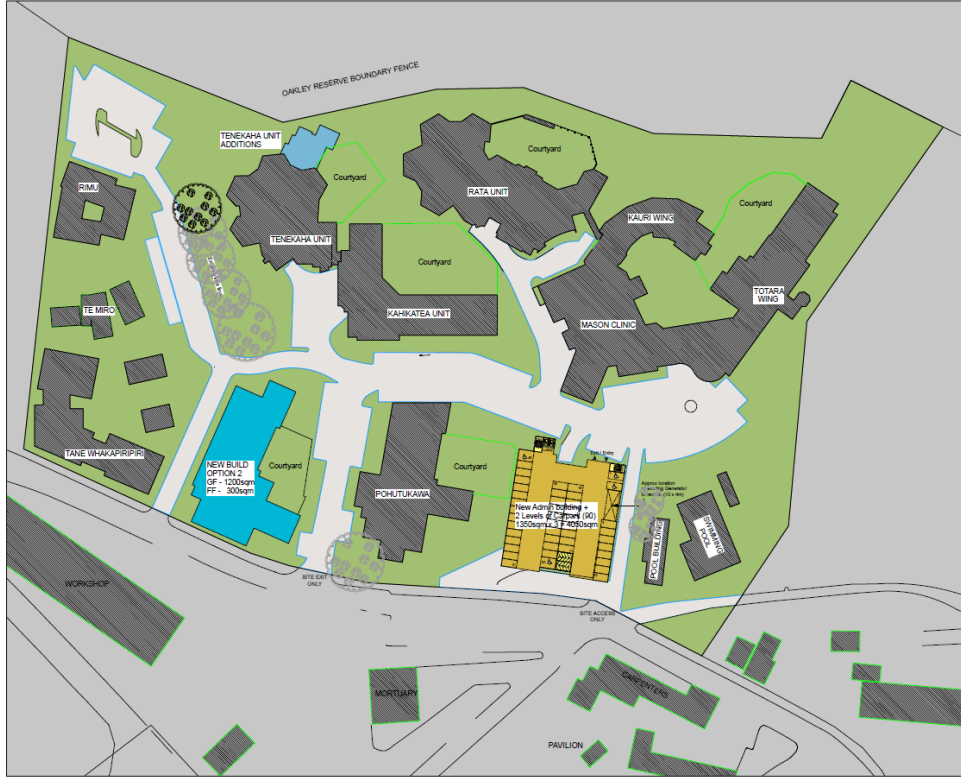
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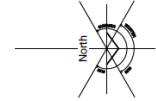
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REVISIONS	DATE	BY	REASON
Klein Limited 27 College Hill, Parnassia Bay Phone: 09 077 1000 Fax: 09 077 1000 Email: sales@kcln.co.nz			
MASON CLINIC OVERALL MASTER SITE PLAN Unibach, Gate 2, Carrington Road, Pt Chev For: HORTON AND PARTNERS CONSULTANTS			
Drawing Title			
Overall Master Site Plan			
Option 2			
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Date	JULY 2014		
Client	eg CD000		
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Job No.	3.1074	Drawing No.	CD-003
		Revision:	A

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Klein



A	15/07/14	JG	MASTERPLANNING ISSUE
REVISION	DATE	BY	REASON
<p>Klein Limited 27 College Hill, Auckland, New Zealand Phone: 09 977 7000 Fax: 09 977 7000 Web: www.klein.co.nz Email: info@klein.co.nz</p> <p>MASON CLINIC OVERALL MASTER SITE PLAN Unit 1, Gate 2, Cavendish Road, Pt Chev Pt Chev, Waitemata District Health Board</p> <p>Drawing Title: Overall Master Site Plan Option 3 - Carpark</p> <p>Drawn: JG Checked: MB</p> <p>Date: JULY 2014</p> <p>Scale: 1:5000</p> <p>Block: 1000 @ A1 / 1:1000 @ A2</p> <p>Job No: Drawing No: Revision:</p> <p>3.1074 CD-004 A</p>			

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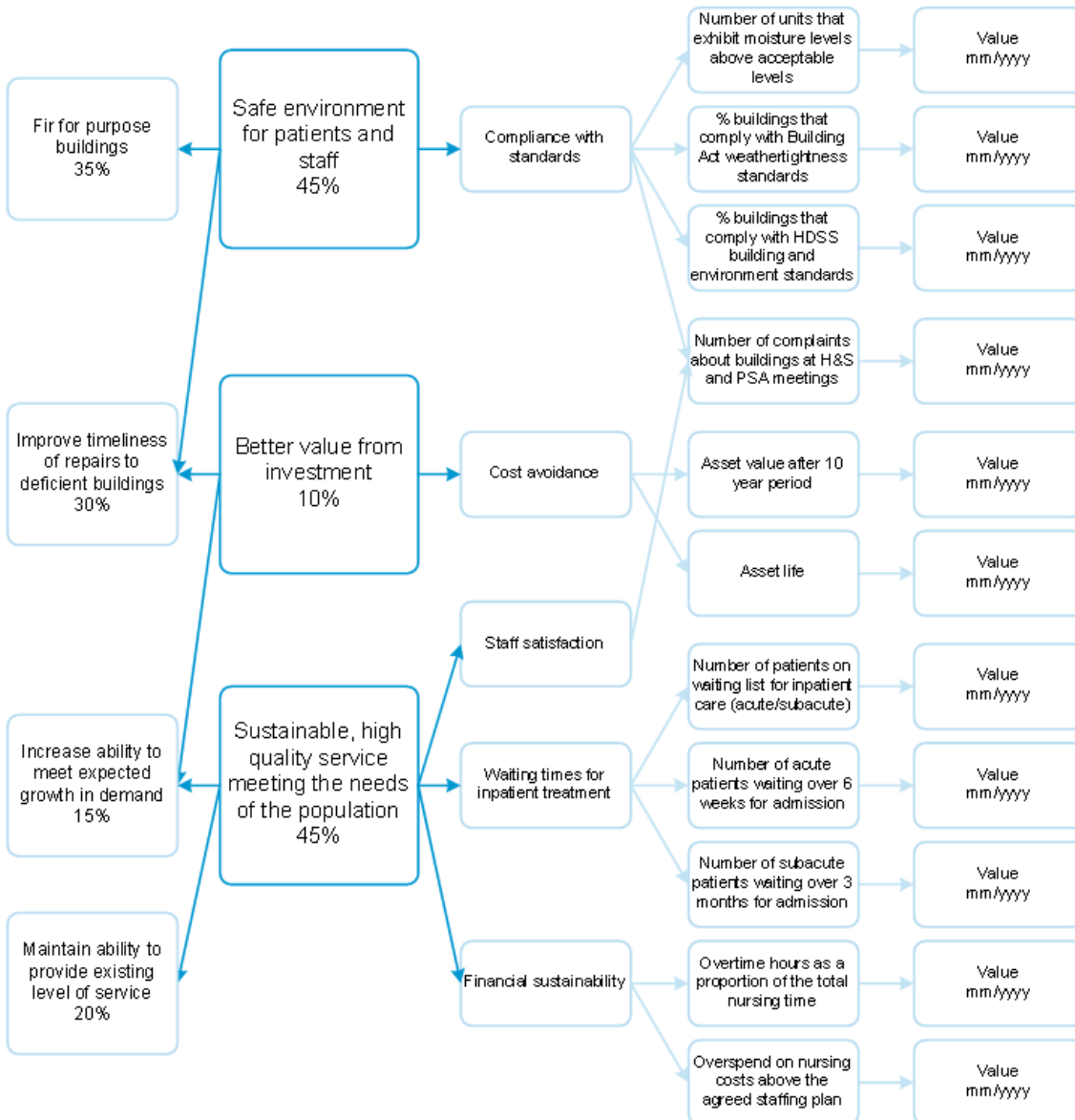
Appendix 5: 2011 Benefits Map (Facilities and Capacity)

Benefit Management Plan
Benefit Map

**Critical Improvements to Forensic
Mental Health Services:
Facilities and Capacity**

Investor: Alan Wilson
Facilitator: Sylvia Meakin
Initial Workshop: 21/09/2011
Version no: 0.2
Last modified by: Sylvia Meakin, 11/10/2011

STRATEGIC INTERVENTIONS ◀ **BENEFIT** ▶ INVESTMENT KPI ▶ MEASURE ▶ TARGET



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Appendix 6: Options Analysis - Additional Capacity

Description	Service Delivery (How)							Service Solution (Who)		
	10 beds	15 beds	On site - extension of existing facilities	On site - new build	Off site - new build	Temporary capacity	Permanent capacity	In-house (WDHB)	Retain CCDHB capacity long-term	Outsource to another provider
Reference	SD1	SD2	SD3	SD4	SD5	SD6	SD7	SOL1	SOL2	SOL3
Investment Objectives										
Ongoing capacity for high complex needs, prison muster and repatriation of patients from CCDHB	N	Y	N	Y	Y	N	Y	Y	Y	Y
Appropriate facilities for Northern Region patients within the Northern Region area	Y	Y	Y	Y	Y	Y	Y	Y	N	N
Support improvement in RFPS building quality by accommodating decanted patients during remedial works	P	Y	N	Y	Y	Y	Y	Y	P	P
Critical Success Factors										
Strategic Fit & business needs	N	Y	N	Y	P	N	Y	Y	N	N
Value for Money	P	Y	P	Y	P	P	Y	Y	P	P
Supplier capacity and capability	Y	Y	Y	Y	?	Y	Y	Y	Y	N
Affordability	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Achievability	Y	Y	Y	Y	P	Y	Y	Y	Y	Y
Summary	N	Y	N	Y	P	N	Y	Y	N	N
Shortlisted Options		↓		↓	↓		↓	↓		
<i>As all CSFs are crucial (not desirable) any option that has a CSF scoring a 'no' is discounted</i>										
Option Title										
Option 1: Do nothing										
Option 2: 15 bed permanent new build offsite	15 beds, off site new build, permanent facility							In-house service provisions		
Option 3: 15 bed permanent new build onsite	15 beds, on site new build, permanent facility							In-house service provisions		

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Appendix 7: QS Updated Concept Estimate May 2015

RLB | Rider Levett Bucknall

MASON CLINIC 15 BED SECURE UNIT - UPDATED CONCEPT ESTIMATE - MAY 2015

Total Cost Summary

GFA: Gross floor area
Rates current at May 2015

Zone	Level	GFA m ²	Cost/m ²	Total Cost
A BASIS OF ESTIMATE				
A1	This Estimate has been prepared			
A2	utilising a combination of			
A3	measured bulk quantities and			
A4	elemental rates obtained from			
A5	similar type projects & priced			
A6	at rates which in our opinion			
A7	are current in the market.			
B DOCUMENTS USED				
B1	The following documents have			
B2	been used in the preparation of			
B3	this Estimate:			
B4	Klein:			
B5	Concept Design report 20/4/2015			
B6	with amended drawings CD series			
B7	101 - 103 Rev C received 12/5/15			
B8	Beca:			
B9	Concept Report 17/4/2015			
C KLEIN SCHEDULE OF ACCOMMODATION				
C1	The Schedule of Accommodation			
C2	Rev G 12/5/2015 is:			
C3	Recommended - 1722 m2			
C4	This GFA excludes GFA taken up			
C5	by the external walls and also			
C6	excludes courtyards, and secure			
C7	vehicle entry			
D RLB ELECTRONIC MEASURE OF GFA				
D1	Ground Floor - 1283 m2			
D2	Level 1 - 489 m2			
D3	TOTAL - 1772 m2			
E BUSINESS CASE G.F.A.				
E1	The Business Case GFA and			
E2	Estimate was based on 1600m2			
F SITE PREPARATION				
F1	Demolition of Puriri Buildg/s			127,000
F2	Site Clearance & Buildg Platform			89,000
				\$216,000
Carried forward				\$216,000

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RLB | Rider Levett Bucknall

MASON CLINIC 15 BED SECURE UNIT - UPDATED CONCEPT ESTIMATE - MAY 2015

Total Cost Summary

GFA: Gross floor area

Rates current at May 2015

Zone	Level	GFA m ²	Cost/m ²	Total Cost
	Brought forward			\$216,000
G	INFRASTRUCTURE WORK			
	G1 Services Infrastructure			500,000
				<u>\$500,000</u>
H	BASE BUILDING COST			
	H1 Structure	1,772	659	1,167,000
	H2 Envelope	1,772	838	1,485,000
	H3 GFA Adjustment	(1,772)		
		<u>1,772</u>	<u>\$1,497</u>	<u>\$2,652,000</u>
I	HARD FITOUT - ARCHITECTURAL			
	I1 Internal Partitions	1,772	380	674,000
	I2 Internal Doors	1,772	254	450,000
	I3 Floor Finishes	1,772	115	204,000
	I4 Wall Finishes	1,772	67	119,000
	I5 Ceiling Finishes	1,772	105	186,000
	I6 Fittings & Fixtures Grp 1	1,772	157	278,000
	I7 Maori Carving Allowance			25,000
	I8 GFA adjustment	(8,860)		
		<u>1,772</u>	<u>\$1,093</u>	<u>\$1,936,000</u>
J	BUILDING SERVICES			
	J1 Hydraulic Services	1,772	270	479,000
	J2 Mechanical Services	1,772	520	922,000
	J3 Fire Protection	1,772	165	293,000
	J4 Electrical Services	1,772	260	461,000
	J5 Special Services	1,772	318	564,000
	J6 Soil Drainage	1,772	27	47,000
	J7 GFA adjustment	(8,860)		
		<u>1,772</u>	<u>\$1,561</u>	<u>\$2,766,000</u>
K	EXTERNAL WORKS			
	K1 Link to Tane Whakapiripiri			Excl.
	K2 External Works & Landscaping			140,000
	K3 Canopies to Secure & public			82,000
	K4 Internal Courtyard	240	317	76,000
	K5 Female & Lounge Courtyards	86	651	56,000
	K6 GFA adjustment	(326)		
				<u>\$354,000</u>
L	PRELIMINARY & GENERAL/MARGIN			
	L1 Main Contractors P&G			1,050,000
	L2 Main Contractors margin			470,000
				<u>\$1,520,000</u>
	Carried forward	5,316	\$1,871	<u>\$9,944,000</u>

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RLB | Rider Levett Bucknall

MASON CLINIC 15 BED SECURE UNIT - UPDATED CONCEPT ESTIMATE - MAY 2015

Total Cost Summary

GFA: Gross floor area

Rates current at May 2015

Zone	Level		GFA m ²	Cost/m ²	Total Cost
		Brought forward	5,316	\$1,871	\$9,944,000
M	GROSS FLOOR AREA ADJUSTMENT		(3,544)		
N	ON COSTS				
	N1	Decanting			Nil
O	FEES				
	O1	Statutory Charges			98,000
	O2	Project Management & Programming			178,000
	O3	Design Consultants/WDHB			1,470,000
					<u>\$1,746,000</u>
P	ESCALATION				
	P1	Escalation to Const Start			216,000
	P2	Escalation to Const Comp Jan 17			220,000
					<u>\$436,000</u>
Q	FF&E Group 2 & 3 (SAY)				\$500,000
R	I.T. HEALTH ALLIANCE (SAY)				\$500,000
S	TOTAL PROJECT CONTINGENCY				
	S1	Contingency Allowance SAY			1,000,000
					<u>\$1,000,000</u>
T	ADJUSTMENT				(26,000)
U	EXCLUSIONS				
	U1	GST			
	U2	Rock excavation			
	U3	Contaminated ground			
	U4	Contract Works Insurance			
	U5	Development Levies			
	U6	Legal costs			
	U7	Funding costs			
					<u></u>
		Total Cost	1,772	\$7,957	\$14,100,000

Mason Clinic – Increasing Regional Forensic Psychiatric Capacity

Appendix 8: Summary Risk Register

		<table border="1" style="font-size: small;"> <tr> <td>5</td><td>Very High</td><td style="background-color: #90EE90;">5</td><td style="background-color: #FFD700;">10</td><td style="background-color: #FF8C00;">15</td><td style="background-color: #FF4500;">20</td><td style="background-color: #FF0000;">25</td></tr> <tr> <td>4</td><td>High</td><td style="background-color: #90EE90;">4</td><td style="background-color: #FFD700;">8</td><td style="background-color: #FF8C00;">12</td><td style="background-color: #FF4500;">16</td><td style="background-color: #FF0000;">20</td></tr> <tr> <td>3</td><td>Medium</td><td style="background-color: #90EE90;">3</td><td style="background-color: #FFD700;">6</td><td style="background-color: #FF8C00;">9</td><td style="background-color: #FF4500;">12</td><td style="background-color: #FF0000;">15</td></tr> <tr> <td>2</td><td>Low</td><td style="background-color: #90EE90;">2</td><td style="background-color: #FFD700;">4</td><td style="background-color: #FF8C00;">6</td><td style="background-color: #FF4500;">8</td><td style="background-color: #FF0000;">10</td></tr> <tr> <td>1</td><td>Very Low</td><td style="background-color: #90EE90;">1</td><td style="background-color: #FFD700;">2</td><td style="background-color: #FF8C00;">3</td><td style="background-color: #FF4500;">4</td><td style="background-color: #FF0000;">5</td></tr> <tr> <td colspan="2"></td> <td>Very Low</td><td>Low</td><td>Medium</td><td>High</td><td>Very High</td></tr> <tr> <td colspan="2"></td> <td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr> </table>					5	Very High	5	10	15	20	25	4	High	4	8	12	16	20	3	Medium	3	6	9	12	15	2	Low	2	4	6	8	10	1	Very Low	1	2	3	4	5			Very Low	Low	Medium	High	Very High			1	2	3	4	5										
5	Very High	5	10	15	20	25																																																											
4	High	4	8	12	16	20																																																											
3	Medium	3	6	9	12	15																																																											
2	Low	2	4	6	8	10																																																											
1	Very Low	1	2	3	4	5																																																											
		Very Low	Low	Medium	High	Very High																																																											
		1	2	3	4	5																																																											
Risk No	Risk Description	Risk Impact	Probability	Impact	Rating	Planned Actions	Probability post mitigation	Impact post mitigation	Rating post mitigation																																																								
1	Unitec restricts car parking, clamping or removing illegally parked cars	- Increased pressure on Mason Clinic site - Council require urgent additional car parking to be provided	2	3	6	- Negotiation with Unitec to allow parking on their land to continue - Consideration of payment to Unitec for parking spaces used	1	3	3																																																								
2	Cost exceeds budget (including contingency)	- Plans are required to be modified to meet budget - Further funds would be sought from WDHB or central Government - Timelines could be extended if revised planning is required, impacting ability to commence the Remedial Works project	3	3	9	- Revised estimate (\$14.1m) advised to Executive, with associated business case submitted for approval - Monitor for design creep on approved GFA - Regular cost checks at each phase of the design - Penalties for late delivery	2	3	6																																																								
3	Car park solution is not approved, for shortfall in parking on the Mason Clinic site	- Resource consent for the additional capacity is not given - Additional capacity cannot be utilised, resulting in: - Existing alternative arrangements (i.e. CCDHB) remaining in place - Waiting times would grow as demand increases	3	5	15	- Resolution of outstanding issues - Internal review of capital investment priorities - Ongoing communication with Council	2	5	10																																																								
4	Resource consent is not granted for the removal of 2-3 plane trees, required to be removed in order to fit the new building on the defined site.	- Design for build needs to be reconsidered - Not removing trees would increase build cost by approximately \$900k	3	4	12	- Obtain design footprint for new build as soon as possible - Design minimises impact - Early application to Council - Discussion ongoing with Ngati Whatua - support in principle for the build and need for tree removal - Proposal to re-use wood in the new facility	1	4	4																																																								
5	Time to build unit exceeds expected timeline	- Delay in decanting with knock-on delay on commencement of Remedial Works project - Delay in availability of permanent additional capacity - Extension of contract with CCDHB, incurring additional excess costs for WDHB and inconveniencing patients and their families	2	4	8	- Progressing decisions and approvals - Continue design work prior to approval to minimise delay - Appoint a strong project manager - Penalties for late delivery	2	4	8																																																								
6	Inability to recruit additional staff required to adequately resource the new unit	- Capacity is constrained to safe levels, based on staffing levels available	2	4	8	- Incremental approach to recruitment, with annual growth - Consider relocation packages for key staff - Plan for transfer of staff from existing Kaupapa Maori service, making it easier to backfill vacancies	1	4	4																																																								
7	Client scope change	- Could increase design/build timeline, cost or both - Delay in decanting with knock-on delay on commencement of Remedial Works project - Delay in availability of permanent additional capacity - Extension of contract with CCDHB, incurring additional excess costs for WDHB and inconveniencing patients and their families	4	4	16	- Strong Project Manager control - Escalation process for change requests, requiring cost and project impact assessment prior to approval	2	4	8																																																								
8	Delay in approval, at WDHB and/or MoH/NHB	- Delay in decanting with knock-on delay on commencement of Remedial Works project - Delay in availability of permanent additional capacity - Extension of contract with CCDHB, incurring additional excess costs for WDHB and inconveniencing patients and their families	4	4	16	- Early engagement with officials at MoH and NHB - Priority for Board approval - fast track process agreed for submission to Board	3	4	12																																																								
9	Inability to provide additional 600m2 of admin accommodation for staff displaced from Puriri, and additional staff for the increased capacity	- Displaced staff will continue to occupy clinical space, impacting on service delivery in the long term	3	2	6	- Options for admin accommodation to be developed alongside planning for car parking	2	2	4																																																								

Mason Clinic – Increasing Regional Forensic Psychiatric Capacity

Appendix 9: Abbreviations

ASCF	Auckland South Corrections Facility
CCDHB	Capital and Coast District Health Board
CFO	Chief Financial Officer
CSF	Critical Success Factor
FF&E	Furniture, fixtures and equipment
FTE	Full Time Equivalent
GFA	Gross Floor Area
HealthA	Health Alliance
ID	Intellectual Disability
ILM	Investment Logic Map
KPI	Key Performance Indicator
MECF	Mount Eden Corrections Facility
MoH	Ministry of Health
NGO	Non-Governmental Organisation
NIDSS	National Intellectual Disability Support Service
NPV	Net Present Value
RFPS	Regional Forensic Psychiatry Services
RIDCA	Regional Intellectual Disability Community Care Agency
WDHB	Waitemata District Health Board

3.2 Mason Clinic – 15 Bed Medium Secure Unit

Recommendation:

That the Board:

- a) **Approve the business case to build a permanent 15 bed medium secure unit on the Mason Clinic site for \$9.8M, noting that \$2.5M of funding had been approved in an earlier decision regarding remedial works for the construction of a temporary facility solely for decanting purposes.**
- b) **Note that since approving the remedial works plan, further discussions with the Ministry of Health have identified additional bed requirements (initially to be used for decanting purposes) and that this is the most economical option to provide the renovation of the existing building stock, and to provide for known, funded growth.**

Prepared by: Ian McKenzie (Manager Regional Forensic Psychiatry Services), Bruce Talbot (Associate Services Manager (RFPS)) and Lisa Dorney, Finance Manager (Operational Finance and Planning)

Endorsed by: Robert Paine (Chief Financial Officer and Head of Corporate Services), Helen Wood (General Manager Mental Health), Dr Jeremy Skipworth (Clinical Director Regional Psychiatry Services) and the Executive Leadership Team

Please refer to the attached Business Case.

15 bed Medium Secure Unit

Mason Clinic 15 Bed Medium Secure Unit

15 bed Medium Secure Unit

Document Draft:	16/7/2014
Prepared By:	Name Ian McKenzie Regional Manager Forensic Psychiatry Services
Input Provided By:	Bruce Talbot, Associate Service Manager Clare McCarten, Associate Service Manager Neville Thomson, Associate Service Manager Lisa Dorney, Operational Finance and Planning Paul Stanbridge, Project Manager Gillian Rheinberger, Project Manager Jeremy Skipworth, Clinical Director Helen Wood, General Manager Louise Ward, Facilities General Manager
Business Case endorsed By:	Project Steering Group
	WDHB Capital and Asset Management Planning Committee
	WDHB Executive Leadership Team
	Northern Region Capital Group as required
Next Steps:	WDHB Audit and Finance Committee consideration
	WDHB Board consideration
	National Capital Committee Consideration (if applicable)

15 bed Medium Secure Unit

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15 bed Medium Secure Unit

Appendices

Appendix	Title
Appendix 1	Mason Clinic overall master site plan
Appendix 2	QS costing – Rider Levett Bucknall
Appendix 3	Financial analysis

15 bed Medium Secure Unit

1. Executive Summary

1.1 Purpose of the Business Case

The purpose of this business case is to gain approval to build a 15 bed medium secure unit with second level office space on the current site occupied by Puriri. This building will initially function as the decant building for the remedial works to occur. These works will occur over a 2 to 3 year period once the new unit is built.

This business case has been peer reviewed by PwC and Health Partners Consulting.

1.2 Business Case/Project Proposal

This 15 bed unit provides the most efficient return on capital and provides capacity for service growth once remedial repairs are completed.

This building needs to be completed and commissioned within 2 years. At the end of the decanting period the building will provide an additional 15 bed unit to accommodate growth. At that time the DHB will satisfy Council car parking requirements.

1.3 Key Drivers for the Project

To enable the remediation of existing buildings, within a confirmed site.

To enable the service to meet growth demands

1.4 Key Objectives and Benefits of Implementing the Project

The 15 bed unit:

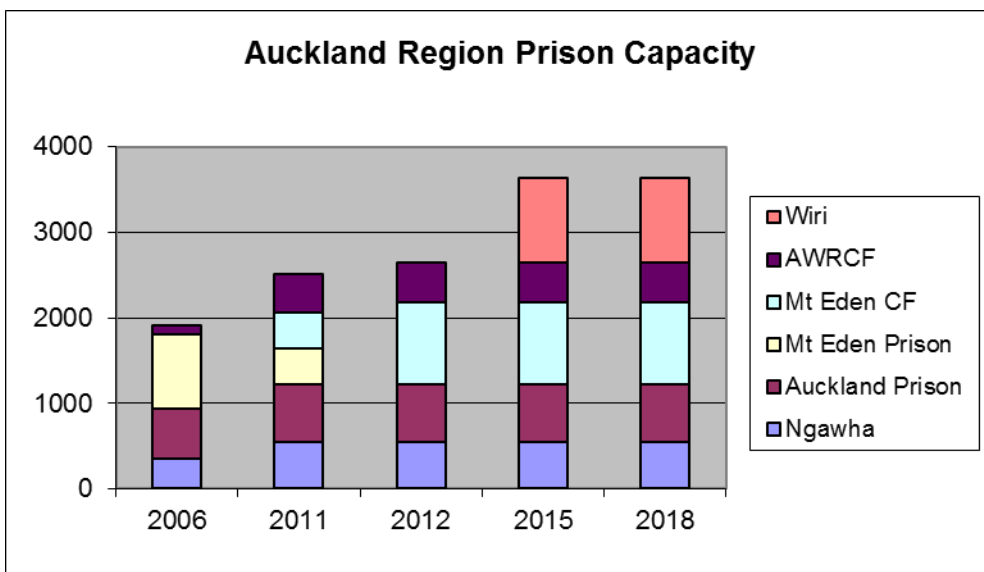
- Is a permanent build providing for more prudent use of capital
- Meets the need for the decant process
- Allows for repatriation of 5 beds from Capital and Coast DHB, provides an additional 5 high and complex beds to meet current demands, and 5 new beds to meet increased demand for the new South Auckland Correctional Facility
- Meets the medium term future needs for forensic beds in the northern region in anticipation of prison muster and regional population growth.
- Enables Tanekaha to be viewed as a future five bed option for growth
- Additional beds have a revenue stream agreed by MoH via forensic top slice. Net effect on profit and loss is a surplus of \$320k per annum

15 bed Medium Secure Unit

Schedule of anticipated future Forensic Inpatient Need

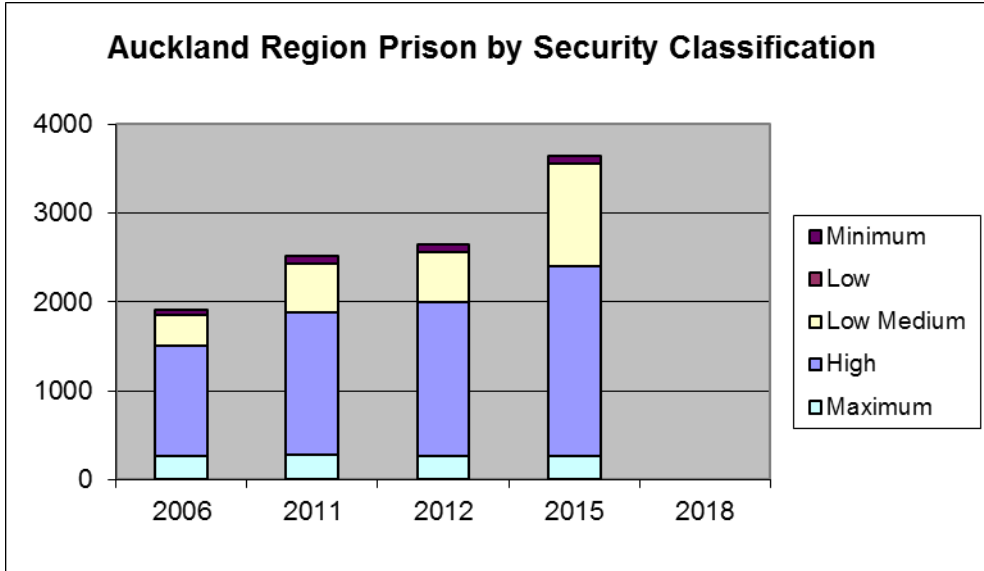
Timeframe	Need	Option
Short Term 1-2 years	Remedy leaky buildings Immediate regional bed demand for people with High and Complex needs	Combine remedial works with permanent bed development. Provide temporary additional beds in existing units
Medium Term 3-5years	Demand driven by: Auckland South Correctional Facility opening Regional High and Complex needs demand Population growth (to date)- Capital & Coast bed repatriation. Office space for additional Clinical FTEs and car parking solution (if required)	Commission 15 permanent beds at conclusion of remedial works programme Administration building and parking solution (if required)
Long Term 5-10 years	Additional step-down Intellectual Disability (ID) beds Beds to meet population/ prison muster growth	Development of step-down hostels on Mason site Additional 5 beds on Tanekaha unit

Anticipated Prison Muster in the Northern Region to 2018

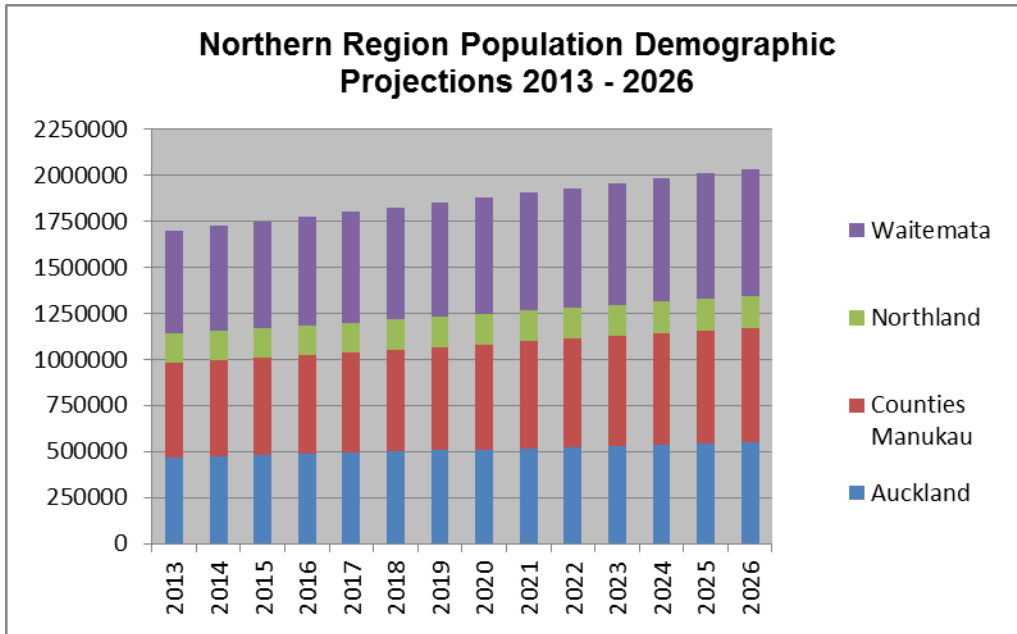


15 bed Medium Secure Unit

Prison Muster Security Classification in the Northern Region



*Information is not available on changes to prisoner security classifications that will result from the rebuild of Auckland Regional Correctional Facility (Paremoremo)



15 bed Medium Secure Unit

1.5 Summary Options Analysis

- New Permanent 15 bed medium secure Unit on the Mason Clinic site.

Build a new 15 bed medium secure unit with office space on the second level situated on the current Puriri Site. This would provide a permanent build going forward. QS estimate based on plan layout of Pohutukawa \$9.7m.

1.6 Summary Total Project Costs and Proposed Project Financing

The total project cost for the 15 bed secure unit with office space is \$9.7m.

Description of cost	\$
Unit build with GFA of 1600	7,200,000
Demolition	75,000
Infrastructure	375,000
Fees and consents	1,165,000
Contingency (10%)	885,000
Total Project Cost	9,700,000

It is proposed that the total capital cost is to be funded fully by WDHB.

Currently there is approved capital funding of \$9.9m for Mason Clinic Remedial Works (project number WF13071). It is proposed that \$2.5m of the total required funding of \$9.7m is to be accessed from this project WF13071. The service would require the DHB to approve additional capital funding of \$7.2m.

New permanent 15 bed medium secure unit on a second site.

This option has been discounted since the DHB has not been able to identify a site that:

- Is readily available for purchase and zoned appropriately
- That would be able to be zoned for a medium secure forensic mental health use
- Is near enough to the existing service to enable access to staff working across both sites
- Whose total cost, both capital and operational, would be affordable
- To build a temporary decant unit on land adjacent to the Mason Clinic. Waitemata DHB has leased land to the south of the current Mason Clinic from Unitec. However, any building construction on that land would be either temporary in nature, or would require to be re-locatable by the end of 2020, and the land made good.

There are also restriction placed on the size and 'nature of the building' that is allowable on that land, such that the 15 bed unit proposed in this business case could not be built there. The resulting facility would therefore be smaller than needed for growth (10 beds), and would require relocation onto the Mason Clinic campus.

15 bed Medium Secure Unit

1.7 Summary Financial Analysis

Profit & Loss Statement

Cost of capital 6%	Initial Investment	Financial Year								Total
		2015-20	2020-25	2025-30	2030-35	2035-40	2040-45	2045-50	2050-55	
\$000										
Total Investment Outflow	-9,700									
Incremental Revenue		0	5,000	5,000	5,000	5,000	5,000	5,000	5,000	35,000
Incremental Cost		-3,904	-3,541	-3,177	-2,813	-2,449	-2,086	-1,722	-1,358	-21,049
Net Profit / (Loss)		-3,904	1,460	1,823	2,187	2,551	2,915	3,278	3,642	13,951

Net Present Value Statement

Discount Rate 8%	Initial Investment	Financial Year							
		2015-20	2020-25	2025-30	2030-35	2035-40	2040-45	2045-50	2050-55
\$000									
Operating Cash Inflows/-Outflows		0	5,000	5,000	5,000	5,000	5,000	5,000	5,000
Net Cashflow	-9,700	0	5,000	5,000	5,000	5,000	5,000	5,000	5,000
Cumulative Cashflow	-9,700	-9,700	-4,700	300	5,300	10,300	15,300	20,300	25,300

The financial modelling of the 15 bed unit generates:

- A negative NPV of \$1.8m. A negative NPV suggests that costs are greater than financial benefits over the project duration.
- The projected profit and loss is favourable. This is due to additional demographic funding made available to operationalize the 15 beds on completion of the remedial works.
- The net book value of the building would be \$8.5m on completion of the remedial works.

1.8 Summary Risk and Constraints Analysis

Not proceeding will mean:

- Remedial works cannot occur
- Inability to provide contracted beds
- Inability to provide the increased clinical capacity to meet the requirement to service the new South Auckland correctional facility.
- More expensive, and less clinically appropriate solutions are implemental to enable the remediation of the current facilities and to provide for fully funded growth
- An inability to service the new South Auckland Correctional facility

15 bed Medium Secure Unit

Things to consider:

- Project cost escalation risks will be minimised by obtaining QS costing estimates of the concept Brief, through value management of the building design and provisions for contingencies and cost escalations within the project.
- As part of the consenting process, the Auckland City Council may require a parking plan to be provided for the campus once the 15 bed unit is operational as additional capacity on the site. Any such proposed solution for a parking solution on the site may include options that require a commitment to provide additional capital at that future time.

Risks to implementing the project within required timeframes need to be minimised by:

- Establishing a project team including WDHB staff, Project Managers, QS, Engineers and Architects ready to progress the project as soon as approval is granted.
- Completion of the concept design, working through the preliminary building designs and value management of the design to enable a fast tracked construction programme.
- An application for resource consent for the building design and building location will need to be lodged by November 2014.
- Establish an appropriate project governance structure for this project including Board oversight and establishment of periodic reporting.

1.9 Summary Project Implementation Timeframes

The Mason Remedial Works project will be implemented over a period of three to four years. The initial stage of developing the 15 bed unit with an expected completion date of December 2016. As part of this a plan to temporarily house staff displaced from Puriri into Cube Portables will have to occur. Following completion, clients currently housed in the Tanekaha unit will be decanted to the new unit. The sequential remediation and decanting program for units at Mason will take three to four years to complete and the whole program is expected to be complete by September 2020.

1.10 Conclusion and Recommendation

It is recommended that the Board:

- (i) Approves total capital costs of \$9,700,000 to construct a new 15 Bed Medium Secure Unit, noting that \$2.5M of the funding for this project was approved by the Board in December 2012.

2. Project Proposal

Facility developments being planned for Mason Campus are about improving and upgrading existing Building stock, infrastructure and increasing capacity to accommodate anticipated regional growth in health services provided by WDHB.

15 bed Medium Secure Unit

3. Project Drivers

This project addresses the two main issues the Mason Clinic is faced with:

- The building of a new 15 Bed medium secure decant unit is required for the Mason Clinic Remedial Works Business Case to commence – this is equivalent to the capacity of the units being repaired.
- The Auckland region is also experiencing a large increase in the local Prison population and demand for acute inpatient beds.

At the end of the remedial process the permanent 15 bed facility will provide a 15 bed increase in capacity that the previous remediation option is unable to provide. As noted above this project will reduce the write off cost in the Remedials Project by the cost of the temporary building (\$4.3M) which can then be applied to the proposed 15 bed unit.

The 15 bed unit is expected to reduce the costs to the remedial project by \$4.6M as the temporary decant building will no longer be constructed.

Programme

Proposed Order of Work:

Remedial Works to Te Miro	Sept 14 – Nov 14
Remedial Works to Pohutukawa and Tane Whakapiripiri	Oct 14 – June 15
Design and construct new 15 bed unit	Aug 14 – Dec 16
Decant Tanekaha	Jan 17 – Aug 20
Remedial Works to Tanekaha	
Reinstate Tanekaha	
Decant Rata	
Remedial works to Rata	
Reinstate Rata	
Decant Kauri	
Remedial works to Kauri	
Reinstate Kauri	
Decant Totara	
Remedial works to Totara	
Reinstate Totara	
Decant Kahikatea	
Remedial works to Kahikatea	
Reinstate Kahikatea	
Repair/reinstate decant building (if required)	Aug 20
Commission new 15 bed clinical building	Sept 20

15 bed Medium Secure Unit

3.1 Current State

Due to the need to provide additional, fully funded beds in the Mason Clinic facility for High and Complex needs patients, it is no longer appropriate to consider building on land leased for the short term. This plan addresses that issue by combining the need for a decant building with the longer term requirement for permanent beds situated on WDHB owned land.

3.2 Future State (Investment Objectives)

The 15 bed Unit

- Is a permanent build on our site providing for more prudent use of capital
- Meets the need for the decant process
- Allows for repatriation of 5 beds from CCDHB, the on-going provision of the 5 high and complex beds currently funded. 5 new beds to meet increased demand from the new South Auckland Correctional Facilities.
- Will provide for Office space on the second level
- Will allow for 5bed future expansion option in future to Tanekaha

4. Project Benefits & Deliverables

Benefit	Description
A new permanent build vs temporary re locatable	In the first instance it will be used to carry out the decant process to allow for remedial works to occur
Improve WDHB's ability to meet expected growth in demand	At the end of the decant process it will be used to house the 5 CCDHB outliers, 5 high complex and allow for the increased demand from the new South Auckland Correctional facility
Future proofing site	The 15 bed build allows for 5 additional beds to meet the demand of the new prison. Tanekaha still has the ability to expand when needed.

4.1 Project Deliverables

Build new 15 Bed Medium Secure Unit
 Allows for decant to address the leaky buildings
 Insures continuity of Service
 Provides for future growth

15 bed Medium Secure Unit

5. Strategic Fit

5.1 Local Strategic Fit

The Waitemata DHB provides specialist regional forensic psychiatry services to meet the health needs of people with significant mental health needs, who are before the courts or are in the criminal justice system. The remedial works programme and additional bed capacity will result in the Mason Clinics ability to provide high quality services in environments that are secure and safe: for the people who use them, for staff and for the wider community

Project Benefits

The creation of a dedicated 15-bed inpatient unit will achieve the following benefits

Outcome	Achieved through	Benefit	Reflects values
Provide an appropriate level of high quality service to those entrusted into our care	<ul style="list-style-type: none"> Excellent assessment and treatment for men and women who are before the courts or in the criminal justice system. Increasing the capacity of the multidisciplinary approach to forensic health care 	<ul style="list-style-type: none"> Supports seamless care Flexibility to meet dynamic service needs Increased patient satisfaction and safeguard the principles of care and respect . Creates strong foundation for staff learning and best care practises. 	<ul style="list-style-type: none"> Recognises everyone matters Compassion Connected Best, better, Brilliant
Meet the demand for secure forensic healthcare	<ul style="list-style-type: none"> Delivers 15 more beds to existing bed stock To create a more diverse and recovery focussed approach through programmes within safe environments for the diverse needs of the forensic population. 	<ul style="list-style-type: none"> Service able to meet demand from Courts, prisons and community Staff able to work to professional scope in safe, secure environments Service users can maximise opportunities for the range of rehabilitation programmes 	<ul style="list-style-type: none"> Connected Everyone matters Best, better, Brilliant Compassion
Financial sustainability	<ul style="list-style-type: none"> Meeting the Ministry of Health request for increased bed capacity. Reduce the duplication of remedial works activity and demand driven growth. 	<ul style="list-style-type: none"> Enables growth within the existing site. Integration of space for clinical staff and inpatient beds on a two story build. 	<ul style="list-style-type: none"> Everyone matters Connected Best, better, Brilliant

15 bed Medium Secure Unit

5.2 Regional Strategic Fit

- Inpatient Assessment and Treatment of Mentally Disabled Offenders**

The primary focus is on inpatient and community rehabilitation across the following units, with 104 inpatient beds in eight units:

Unit Name	Description
Pohutukawa	10 bed medium secure unit used for the assessment & rehabilitation of intellectually disabled offenders. Also includes office space for Quality/Education team and ID community liaison team.
Tane Whakapiripiri	10 bed minimum secure Kaupapa Maori rehabilitation unit.
Tanekaha	10 bed minimum secure rehabilitation unit.
Rata	15 bed long term secure rehabilitation unit
Kahikatea	20 bed minimum secure rehabilitation unit
Kauri	15 bed medium secure admission units
Totara	15 bed medium secure admission units
Rimu	9 step down bed hostel
Kowhai Building	Office space for Court Liaison and Community Forensic Teams. Also Chaplains and Consumer Advisors.
Puriri Building	Administration block with Service Management, Clinical Director, Medical Records and Prison Team.
Te Miro	Maori and Pacific Nations Resource Centre, office space for some cultural advisors

- Community Forensic Services**

Forensic Consultation Liaison Services are provided to local Mental Health Services regionally and assistance is given in developing and implementing effective plans for risk assessment management. The Community Forensic Team provides clinical care for clients in the “step down” beds; case manages high risk forensic clients in the community and ensures that there is an appropriate transition of clients from the forensic inpatient units to local Mental Health Services.

There are twenty step-down beds provided in partnership with NGO’s:

- 5 Pacific Nations Beds
- 5 Kaupapa Maori Beds and
- 10 Mainstream Beds

Access to flexi funding is available for individualised packages of care.

- Intellectually Disabled Offenders’ Community Care Team**

This team provides care under Intellectual Disability Compulsory Care and Rehabilitation Act, 2003 for people who are referred by RIDCA. There is a 10 bed intellectual disability secure unit at Mason Clinic, one of the two National Intellectual Disability Support Service (NIDSS) units in the country serving the upper half of the North Island for intellectually disabled offenders. There is also a four FTE community Intellectual Disability (ID) liaison team.

- Court Liaison Team**

15 bed Medium Secure Unit

The Court Liaison Team has a presence in every major Court in the Auckland and Northland regions. Court Liaison's primary functions are to provide psychiatric assessment and informal advice to the Court on the appropriateness of formal psychiatric reports and/or diversion to Mental Health Services.

- **Regional Population Demographics**

As Forensics services are provided regionally, the regional demographics and projected trends are briefly outlined below:

- The Northern Region is made up of four DHBs: Counties Manukau, Auckland, Waitemata and Northland. At the 2006 Census the Northern region as a whole had a usually resident population of 1,467,756. This was 36% of the total New Zealand population. Waitemata DHB made up 33% of the Northern Region population, Counties Manukau 30%, Auckland DHB 28% and Northland DHB 10%. Between the 2001 Census and the 2006 Census, the Northern region experienced population change of 10.5%. This was a higher rate of growth than the national inter-censal change of 7.2%.
- At the 2006 Census the Northern Region population was 12.5% Maori, 11% Pacific, 15.6% Asian and 54.3% European (including "New Zealander"). The remaining 6.6% being "Other" or "Not Applicable".
- At the 2006 Census 10.3% of the Northern Region population was over the age of 65. This was less than the comparable national rate of 12.3%.
- The latest DHB projections from Statistics New Zealand (2007 release) show that the Northern Region is expected to grow to a population of around 1,789,000 by the year 2016. This would represent population growth between 2006 and 2016 of 13.9%. During the same period the national population as a whole is expected to grow at the lesser rate of 8.9%.
- The Northern region has the fastest growing population nationally, largest migrant population and greatest inequalities for Maori and Pacific peoples accessing services.
- Along with expected general population growth, it is noted that the prison muster numbers are expected to grow significantly until 2015.

South Auckland Prison opens May 2015 as part of Corrections policy to house inmates in their region of origin. It also allows them to close old obsolete facilities. Additional prison beds will result in greater requirement for treatment.

5.3 National Strategic Fit

This business case is aligned with the national and regional service framework for forensic expectations that WDHB will be capable of continuing to provide regional forensic services from clinically safe and fit for purpose facilities. There are limited facilities around NZ from which forensic psychiatric services can be provided, with WDHB holding the northern region contract for such services. These services support the justice and corrections institutions in the northern region, as such ensuring that building infrastructure integrity is maintained and compliance will be in line with national and regional service framework.

With the reconfiguration of corrections and an increase in Auckland region with South Auckland Correctional Facility we become the largest provider of forensic services to corrections in NZ. The beds are seen by the Ministry as a resource nationally important and the increase in bed capacity is strongly supported by the Ministry/Director of Mental Health.

15 bed Medium Secure Unit

6. Critical Success Factors

Approval of Capital expenditure

Need to obtain Unitec permission to site cube portables for administration staff on leased land. If consents are not forthcoming the service will house administration staff temporarily in cube portables on the Mason site – DHB owned land

Consent from Council.

Meeting key time lines to ensure buildings do not deteriorate further

Maintain healthy environment for Service users and staff during works program

Meeting increased demand enables service to operate

7. Project Costs

Description of cost	\$
Unit build with GFA of 1600	7,200,000
Demolition	75,000
Infrastructure	375,000
Fees and Consents	1,165,000
Contingency	885,000
Total Project Cost	9,700,000

8. Project Financing

It is proposed that the total capital cost is to be funded fully by WDHB.

Currently there is approved capital funding of \$9.9m for Mason Clinic remedial works (project number WF13071). It is proposed that \$2.5m of the total required funding of \$9.7m is to be accessed from this project WF13071. The service would require the DHB to approve additional capital funding of \$7.2m.

15 bed Medium Secure Unit

9. Financial Analysis and Affordability

9.1 Key Assumptions

Capital Expenditure	<p>The total project costs used in this analysis is \$9.7m as broken down below:</p> <table border="1"> <thead> <tr> <th></th> <th>\$</th> </tr> </thead> <tbody> <tr> <td>Unit Build</td> <td>7,200,000</td> </tr> <tr> <td>Demolition</td> <td>75,000</td> </tr> <tr> <td>Infrastructure</td> <td>375,000</td> </tr> <tr> <td>Fees and consent</td> <td>1,165,000</td> </tr> <tr> <td>Contingency</td> <td>885,000</td> </tr> <tr> <td>Total Project Cost</td> <td>9,700,000</td> </tr> </tbody> </table> <p>The capital cost estimates were prepared by quantity surveyors Rider Levett Bucknall, July 2014.</p>		\$	Unit Build	7,200,000	Demolition	75,000	Infrastructure	375,000	Fees and consent	1,165,000	Contingency	885,000	Total Project Cost	9,700,000
	\$														
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Demolition	75,000														
Infrastructure	375,000														
Fees and consent	1,165,000														
Contingency	885,000														
Total Project Cost	9,700,000														
Demographic Growth	Demographic funding made available to operationalize the beds on completion of the remedial works will generate a contribution of \$1m contribution per year.														
Depreciation Rates	Depreciation rates used are consistent with WDHB accounting policy.														
Discount Rate – Net Present Value	The discount rate applied in the Net Present Value analysis is 8% per NZ Treasury/National Health Board guidelines.														
Opportunity Cost of Capital	It is proposed that this project is funded by WDHB cash, therefore there is an opportunity cost of capital as the cash could have alternatively been used to (i) repay debt, (ii) repay equity, or (iii) invest on money market instruments and earn interest income. The rate applied in the P&L is 6%.														

9.2 Financial Projections

See page 27.

10. Project Constraints

Council impact on allowing design process

Still need to obtain Unitec permission to site cube portables on leased land.

Council requirements re site coverage and impact on car parking (separate business case completed)

15 bed Medium Secure Unit

11. Risk Analysis and Management

The key risks to this project and mitigation strategies include:

- Rapid deterioration in the condition of buildings requiring urgent decanting of all units at the same time.
- Temporary remedial works that have already commenced and will be on going throughout the decant and remedy period will assist to mitigate against this risk.
- On-going air testing of all the buildings has been occurring and we now have examined the data re frequency going forward to monitor the buildings will ensure that any deterioration in air quality is identified early on to mitigate health risks for clients, families and staff. The flexible decant staging can be amended to prioritise remediation of buildings most at risk.
- It is noted that while the remedial program will seek to complete the most at risk buildings first, if one of these fail prior to decant and remedial work commencing, this puts the whole project at risk as there may not be a suitable location at Mason Clinic to accommodate the clients affected there is no spare decanting area remaining vacant at any time during the project.
- Rigorous project management also needs to be applied to this building work

12. Project Implementation

Proposed Order of Work:

- (i) Remedial Works to Te Miro
- (ii) Remedial Works to Pohutukawa and Tane Whakapiripiri
- (iii) Installation of temporary buildings on Unitec land
- (iv) Decant Puriri to Unitec temporary buildings
- (v) Construct new clinical building
- (vi) Decant Tanekaha
- (vii) Remedial Works to Tanekaha
- (viii) Reinstate Tanekaha
- (ix) Decant Rata
- (x) Remedial works to Rata
- (xi) Reinstate Rata
- (xii) Decant Kauri
- (xiii) Remedial works to Kauri
- (xiv) Reinstate Kauri
- (xv) Decant Totara
- (xvi) Remedial works to Totara
- (xvii) Reinstate Totara
- (xviii) Decant Kahikatea
- (xix) Remedial works to Kahikatea
- (xx) Reinstate Kahikatea

15 bed Medium Secure Unit

12.1 Implementation Timeline

KEY DELIVERABLE 15 Bed Unit	End date
A&F approval of the Business case	July 2014
Design Team Procurement	Sept 14
Design	Jan 15
Resource Consent & Building Consent	Mar 15
Contractor Procurement	April 15
Commence construction.	May 15
Practical Completion.	Dec 16
Hand over to Service and Operational Commissioning	Dec 16
Opening Hand over to Service.	Dec-16

12.2 Change Management

Implementation on this project will impact on staff, clients, clients' families and on operational costs for the service and therefore needs considerable attention to be given to appropriate change management processes.

All units at Mason Clinic function very differently in purpose designed buildings that both staff and service users are familiar with. To facilitate the remedial works on site while maintaining clinical care has required careful planning. The greatest risk to Staff, Service Users and possibly the community will be at each stage we make the initial transfer to a new environment.

The service plans an increase in Registered Nurse number in order to:

- Help monitor the move into the new environment; this will be stressful to all and it is possible that some of the service users could decompensate, leading to an overall increase in acuity.
- A new environment requires time for all to learn where things are and to instigate a revised programme.
- Possible risk around security and safety needs to be assessed and policies adjusted to take in to account.
- Increased likelihood of whanau wanting to visit to see the new environment.

The increase in registered nursing numbers will be short term – i.e. to cover the first four weeks of each unit move/decant is covered by the Mason Clinic Remedial Works Business Case

Unions will be involved during the process.

12.3 Project Structure, Monitoring and Reporting

The Mason Clinic Project governance structure follows similar approaches to other major redevelopment projects undertaken by WDHB. This includes a Project steering group that is already in place and comprises Forensic Services clinical staff, management staff, Finance, Facilities and with a WDHB ELT member (CFO) and MH GM as the sponsor of the project.

15 bed Medium Secure Unit

A monthly update report is provided to the Audit and Finance Committee on project progress as well as progress on the litigation process. A project assurance update will also be provided to the Board via the A&FC regarding status of the project, that is, if the project is on time, on budget and able to achieve the objectives of the business case

12.4 Post Implementation Evaluation

As the project is being implemented in stages, on-going review of the procurement process and project costs will be undertaken to ensure that learnings from the last decant and remedial works are taken into consideration for future phases of the project. The Corporate funding pool recommended to be set aside to manage any potential risk of the actual state of the building walls (unquantifiable without stripping the building) will be reviewed on an on-going basis to ensure that there is sufficient funds to mitigate this risk or to release the funds for other WDHB priorities.

On completion of the whole project, detailed post implementation review will be completed and presented to the Board via the Audit and Finance Committee.

13. Recommendation

The Mason Clinic buildings from which Regional Forensic Mental Health Services are provided are failing significantly. A robust business case development process has been followed, applying the BBC methodology and commencing with ILM workshops to clearly define the problems and identify a range of options for resolving the problems. The original business case was approved by the Board in 2012.

This business case is being submitted as there has had to be a major rethink as during application for resource consent Unitec declined to sign off a design for a 15 bed requesting this be 10 beds only.

This proposal will deliver a better long term outcome for the Mason Campus to insure the DHB has the ability to meet future growth. At the same time looking to invest money in a new build rather than a temporary building makes better financial sense.

It is recommended that the Board:

- a) Approve the business case to build a permanent 15 bed medium secure unit on the Mason Clinic site for \$9.8M, noting that \$2.5M of funding had been approved in an earlier decision regarding remedial works for the construction of a temporary facility solely for decanting purposes.
- b) Note that since approving the remedial works plan, further discussions with the Ministry of Health have identified additional bed requirements (initially to be used for decanting purposes) and that this is the most economical option to provide the renovation of the existing building stock, and to provide for known, funded growth.

15 bed Medium Secure Unit

Appendix 1: Mason Clinic overall master site plan



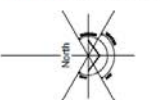
Klein



3.1074 CD-000 A



Klein

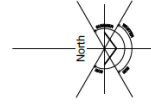


3.1074 CD-001 A

15 bed Medium Secure Unit



Klein



A	13.07.14	JG	MASTERPLANNING ISSUE
REVISION	DATE	BY	REASON
<p>Klein 27 Chapel Hill, Auckland, New Zealand Phone: 09 271 7000 Fax: 09 271 7000 www.klein.co.nz Email: sales@klein.co.nz</p> <p>MASON CLINIC OVERALL MASTER SITE PLAN Unit 10, Gate 2, Cavendish Road, Pt Chev P.O. BOX 100000, AUCKLAND</p> <p>Drawing Title: Overall Master Site Plan Option 3 - Carpark</p> <p>Drawn: JG Date: JULY 2014 Checked: MB</p> <p>Client: WDC Scale: 1:500 @ A1 / 1:1000 @ A0 Job No: Drawing No: Revision: 3.1074 CD-004 A</p>			

Do not scale off the drawings. The Contractor must verify all dimensions on site before commencing any work. Copyright ©

15 bed Medium Secure Unit

Appendix 2: QS Costing

RLB | Rider Levett Bucknall

MASON CLINIC - CONCEPT ESTIMATE MENTAL HEALTH CLINICAL BUILDING

Total Cost Summary

GFA: Gross floor area
Rates current at July 2014

Zone	Level	GFA m ²	Cost/m ²	Total Cost
A BASIS OF ESTIMATE				
A1	This Estimate has been prepared			
A2	utilising a combination of GFAs			
A3	& Elemental Analysis obtained			
A4	from similar type projects &			
A5	priced at rates which in our			
A6	opinion are current at July 2014			
<hr/>				
B DOCUMENTS USED				
B1	The following documents have			
B2	been used for the preparation of			
B3	this Estimate			
B4	Email of 2/7/2014 from Bruce			
B5	Talbot & discussions with Bruce			
<hr/>				
C DEMOLITION OF PURIRU:				\$75,000
D MENTAL HEALTH CLINICAL BLDG:				
D1	This unit is assumed to be			
D2	similar to the existing			
D3	Pohutukawa facility with a			
D4	similar GFA			
D5	Mental Health Building			
		1,600	4,500	7,200,000
		1,600	\$4,500	\$7,200,000
E INFRASTRUCTURE				
E1	Allowance for Infrastructure			375,000
				\$375,000
F ESCALATION				Excl.
G FEES & CONSENTS				
G1	Mental Health Building			1,165,000
				\$1,165,000
H CONTINGENCY SUM				\$885,000
I EXCLUSIONS				
I1	GST			
I2	Escalation (Allow 4%/annum)			
I3	FF&E Group 2 & 3			
I4	Decanting			
Carried forward		1,600	\$6,063	\$9,700,000

15 bed Medium Secure Unit

RLB | Rider Levett Bucknall

MASON CLINIC - CONCEPT ESTIMATE MENTAL HEALTH CLINICAL BUILDING

Total Cost Summary

GFA: Gross floor area
Rates current at July 2014

Zone	Level	GFA m ²	Cost/m ²	Total Cost
	Brought forward	1,600	\$6,063	\$9,700,000
	Total Cost	1,600	\$6,063	\$9,700,000

15 bed Medium Secure Unit

Appendix 3: Financial Analysis

Forecast Profit and Loss

Cost of Capital		6%									
Project Life Years		40									
Financial Year		Initial	Years								
		Investment	1-5	6-10	11-15	16-20	21-25	26-30	31-35	36-40	Total
		2015-20	2020-25	2025-30	2030-35	2035-40	2040-45	2045-50	2050-55		
Investment											
Buildings & Plant		-9,700									
Total Investment Outflow		-9,700	0	0	0	0	0	0	0	0	
Total Inflows			0	5,000	5,000	5,000	5,000	5,000	5,000	5,000	35,000
Expenditure											
Opportunity cost of capital			-2,692	-2,328	-1,964	-1,601	-1,237	-873	-509	-146	-11,349
Depreciation			-1,213	-1,213	-1,213	-1,213	-1,213	-1,213	-1,213	-1,213	-9,700
Total Expenditure		0	-3,904	-3,541	-3,177	-2,813	-2,449	-2,086	-1,722	-1,358	-21,049
Net Profit / (Loss)			-3,904	1,460	1,823	2,187	2,551	2,915	3,278	3,642	13,951

Net Present Value

Discount Rate		8%									
Project Life Years		40									
Financial Year		Initial	Years								
		Investment	1-5	6-10	11-15	16-20	21-25	26-30	31-35	36-40	
		2015-20	2020-25	2025-30	2030-35	2035-40	2040-45	2045-50	2050-55		
Investment											
Buildings & Plant		-9,700									
Total Investment Outflow		-9,700	0	0	0	0	0	0	0	0	0
Total Inflows			0	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000
Total Expenditure		0	0	0	0	0	0	0	0	0	0
Operating Cash Inflows/-Outflows		0	0	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000
Net Cashflow		-9,700	0	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000
Cumulative Cashflow		-9,700	-9,700	-4,700	300	5,300	10,300	15,300	20,300	25,300	
Investment Evaluation											
Net Present Value		-1,768		Non-discounted Cash Payback						14.91 Years	
Internal Rate of Return		6.68%									

Tanekaha Unit Not fit for Purpose Replacement Project

**Mason Clinic
Tanekaha Unit Not Fit For
Purpose Replacement
Project**

Tanekaha Unit Not fit for Purpose Replacement Project

Document Version:	5.1 (2 December 2016)
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Business Case endorsed By:	
Next Steps:	

Tanekaha Unit Not fit for Purpose Replacement Project

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Tanekaha Unit Not fit for Purpose Replacement Project

1. Executive summary

1.1 Key points

The Tanekaha unit at the Mason Clinic is one of many units on the campus failing, suffering from weather tightness and “leaky building” issues. Without remediation, it is expected that the Tanekaha unit will have to close in the near term as the associated health risks from toxic mould spores to patients and staff will be too high. As such, there is also a risk to the ability to continue to provide regional forensic psychiatry services to patients in the Northern Region of New Zealand.

This single stage business case sets out the proposed solution to address the problems identified with the Tanekaha unit. This business case has been prepared in the wider context of the forthcoming master plan for the Mason Clinic campus, the long term planning for the neighbouring Unitec Campus and a broader remedial programme for all the “leaky buildings” in the Mason Clinic campus. Tanekaha is in the worst condition, and is the unit with the most pressing need for a solution. The continued deterioration of the Tanekaha unit means that a solution is required before the master planning processes are completed. The proposed investment requires a relatively low-level of capital investment and is considered low risk as the investment represents no material change in the scale or scope of services provided at the Mason Clinic. As such a single stage business case is considered appropriate.

The proposed solution is to build a new 15 bed medium secure unit on the Mason Clinic campus, but not on the existing Tanekaha site. Tanekaha is currently a minimum secure 10 bed unit, but alignment to long term planning processes and the recommended model of care means that a new 15 bed unit is considered the preferred option to start the wider remedial process for the site.

The proposal to build a medium secure unit is supported by the master plan. Firstly, the proposed location for the new building is in the medium / high secure zone on campus and supports the development of non-core forensic services at the Mason Clinic. Secondly, the next building requiring remediation after Tanekaha is Rata which is a medium secure unit. If Tanekaha is built as a minimum secure unit and Rata is decanted into the decant 15 bed secure unit then there is no on-site capability to rehouse patients to facilities above minimum secure levels which does not mitigate the risk to the continuity of service at Mason Clinic. This approach provides alignment with the master plan as well as a risk mitigation for the remediation program. Thirdly, this option supports delivery of the correct number of beds at each security level in line projections under the proposed master plan.

Investigation of the cost of remedial works found that the cost of a new building was not significantly higher than remediation, and it provided a range of wider clinical benefits.

This business case seeks approval for the proposed capital investment of \$17.5m.

It is expected that after the campus redevelopment is completed, the number of beds and units at each security level will not change, and overall operating costs will be no higher. For example, the Kahikatea unit is currently a 20 bed minimum secure unit, but as part of the wider redevelopment of the campus, it will be scaled back to a 15 bed minimum secure unit, with a net change of zero beds at each security level. No additional operating expenditure is being sought, as Waitemata DHB

Tanekaha Unit Not fit for Purpose Replacement Project

expects that no new staff will be needed. The staff required to operate the new unit will be re-allocated from existing units at the Mason Clinic.

1.2 How we got here

In early 2011, it was identified that several of the buildings at the Mason Clinic suffered from “leaky building” issues, which posed health risks to patients and to staff. For example, prolonged exposure to the damp conditions and resulting mould spores can cause respiratory illnesses. The risk to patient and staff health is considered significant, and will increase as the buildings continue to deteriorate. As such, Waitemata District Health Board (DHB) agreed to undertake remedial work on the leaky buildings.

Waitemata DHB commissioned expert quantity surveyors to investigate remedial work (e.g. re-cladding) for the leaky buildings. Waitemata DHB discovered that the cost of construction of a new unit was not significantly higher than remedial work and there are a range of inherent construction risks involved with remedial work compared to construction of a new building. This included issues like underlying deficiencies in the structural timber, which would only be known after the remedial work had begun, imposing new costs. Meanwhile, a new building provides a range of additional benefits, for example, configuring the unit to meet the recommended model of care. Waitemata DHB considered that the clinical benefits from providing services using the recommended model of care are significant.

Waitemata DHB’s proposed investment in the Mason Clinic campus has been complicated by the realisation that this is in conflict with Unitec’s vision for the redevelopment of their campus. To resolve this conflict, an all of government review was recently completed by the Ministry of Business, Innovation and Employment (MBIE) to advise ministers. A preferred direction from Government is anticipated which will have a major impact on the future master plan for the Mason Clinic campus.

The master planning process underway for the Mason Clinic site has therefore included the three potential outcomes from the MBIE review:

- The Mason Clinic campus must provide its services from its current campus, without any additional land.
- Waitemata DHB procures an additional 2.2ha of neighbouring Unitec campus land to enlarge the Mason Clinic campus.
- The Mason Clinic is relocated to land on a new greenfield site.

The current indications from the MBIE review suggest that the Mason Clinic will stay in its current location, and WDHB will be given the opportunity to purchase an additional 2.2ha of land (Option B). On this basis, Waitemata DHB has progressed with its plan for a solution for the Tanekaha unit, the unit which most urgently requires remedial attention. If a new build is approved, it is expected to be located on the Mason Clinic campus where the swimming pool is currently situated, consistent with master planning to date. However, if the master plan for the Mason Clinic concludes with no additional land, the new build will likely be in that same location, but a reconfiguration of carparking is likely to be required.

This business case seeks approval for new Crown funding of the preferred option, which has been developed in conjunction with the development of master plans for the current, or an expanded

Tanekaha Unit Not fit for Purpose Replacement Project

campus. A programme business case will be prepared in 2017 to consider the options for the campus in the master plan, including a campus-wide solution for the units suffering from leaky building issues.

1.3 The case for change

There are three key drivers for the proposed investment. First, the Mason Clinic campus suffers from weather tightness and leaky building issues. Several buildings have been identified as failing significantly, with severe and significant risks to the health of patients and staff. The Tanekaha unit has been identified as the building that has the most severe issues and poses the greatest risk to human health. Remedial works for the other units will follow in succession. A programme business case will be completed in 2017 to address the series of remedial works which will be required.

Without remediation to the Tanekaha unit, it is expected that the level of risk will be too great and the unit will have to close in the near term. This creates a risk to the continuity of regional forensic psychiatry services at the Mason Clinic which is unacceptable. The demand for mental health services is expected to increase, due to a growing prison muster – mental health disorders and illnesses are up to five times more prevalent among prisoners than in the general population – so the risk and consequential adverse outcomes of doing nothing is likely to increase over time.

Second, the Mason Clinic facilities have been developed in a piecemeal way over the last 22 years and the units are dated. They no longer meet the recommended model of care (consistent with current best practice). Third, there is a broader plan to redevelop the campus (the master planning process), which is due to be completed in the first quarter of 2017. An overall review of the units and their configuration (e.g. the number of beds per unit, the availability of ensuite facilities, seclusions rooms in minimum secure units are no longer required) will ensure that the units support the recommended model of care.

The master plan for the Mason Clinic site is expected to be completed and agreed by Waitemata District Health Board (DHB), Treasury and the Ministry of Health (MoH) in 2017, after Unitec finalises its land use plans for its campus. The Unitec Institute of Technology (Unitec) redevelopment will strongly influence the master plan for the Mason Clinic. If residential housing is developed at the southern part of Unitec's campus, the layout of the Mason Clinic campus will need to be configured to provide a natural perimeter and progression between the campus and the residential development. This is to support the privacy of both the Mason Clinic patients and the residents.

There are three broader options for the Mason Clinic's location, which the Ministry of Business, Innovation and Employment (MBIE) has a role in determining, given that the Crown owns the land which Unitec is situated on and it has an interest in delivering more housing in Auckland. A ministerial decision will determine which of the following options will proceed for the Mason Clinic:

- Option A – Remain on Mason Clinic campus with no additional land
- Option B – Remain on Mason Clinic campus with 2.2 ha of additional land
- Option C – Move to a greenfield site local to the Mason Clinic campus

Regardless of the outcome of the ministerial decision, the case for change and need to construct a new unit remains. The design and cost estimates are not likely to materially change due to the location decision.

Tanekaha Unit Not fit for Purpose Replacement Project

The outcome of the ministerial decision for which of the three options will proceed, will significantly impact the master plan for the Mason Clinic. One of the critical outcomes is for the land use around the campus. If the area around the campus is developed for residential housing, then the layout of the Mason Clinic campus will be configured so that there is a sense of security without a physical barrier, and units will be oriented such that the privacy of patients and neighbouring residents is protected as much as is practical.

The availability of land also determines the service range, and associated building type, to be constructed. If additional land is available for the Mason Clinic, it is expected that the campus will be developed for core forensic and non-core forensic services on the same site. This also influences the layout of the campus, for example adult forensic units need to be separated from youth units, and minimum secure services for and high and complex needs patients may also need separation from other forensic units.

The planning process for the Unitec redevelopment and the master planning for the Mason Clinic site is on-going. However, there is an urgent need to find a solution for the Tanekaha unit, because of its condition, ahead of the completion of the master planning process. This business case, and the development of a solution for the Tanekaha unit, is being undertaken in conjunction with and in alignment to the wider master planning process. While the master planning process is on-going, the fundamental drivers for this business case are well established and will not change. Further refinement of the master planning will not compromise the proposed options.

1.4 Options analysis

1.4.1 The long list of options

The project working group developed a long list of options to resolve the failing Tanekaha unit. The working group considered service solutions as well as who was best placed to provide the solution and the implementation timeframe for the solution.

There were 17 service solutions identified, which covered a range of features including:

- the level of permanency (e.g. temporary repairs, permanent repairs)
- the use of the Tanekaha unit (e.g. repair, remediate or a new building)
- the size of a new unit (e.g. same size or expanded size)
- the location of a new unit (e.g. on existing Tanekaha site, different location on campus, different location)
- utilisation of existing resources (e.g. repurposing an existing building).

The long list of options did not specify the security level in the 17 service options.

A multi-criteria analysis was conducted by the project working group to identify an initial preferred set of options.

The working group's preferred service solution was for a new building at the Mason Clinic (but not on the existing Tanekaha site), with an expanded number of beds. The working group also preferred that Waitemata DHB would be the organisation responsible for delivering the solution.

One notable element of this assessment is that a larger solution to the existing Tanekaha unit was preferred to a same-size solution. A 15 bed unit is consistent with the current recommended model of care, as opposed to the current 10 bed. This will also allow the reduction of the Kahikatea unit

Tanekaha Unit Not fit for Purpose Replacement Project

from 20 beds to 15 as part of the wider campus redevelopment, which is also consistent with moving toward the current recommended model of care.

1.4.2 The short list of options

The project group refined its understanding of the options in the context of the master planning and knowledge of the state of Tanekaha, as well as better understanding of the broader remedial programme.

A previous business case for a new 15 bed medium secure unit was approved by the Capital Investment Committee (CIC) in 2015, which was to support forecast growth in demand for mental health services at the Mason Clinic and to support the remedial programme.

It was initially envisaged that the new unit would support sequential decanting. Patients would move into the new unit, while their home unit was being remediated. However, as the project group gained further insight on the remediation works, it was discovered that the cost of remediation was not much less than construction of a new building, while the new building provided additional clinical benefits to patients, such as providing services in line with the recommended model of care.

As a result the following options are included in the short-list for this business case:

- Remediation of Tanekaha unit, including re-cladding and like-for-like remedial works. This is option 0.
- A new 15 bed unit on the same site as the current Tanekaha unit. This is option 1.
- A new 15 bed unit on a different site to Tanekaha but at the Mason Clinic. This is option 2.
- A new 15 bed unit on a new greenfield site (not on the Mason Clinic site). This is option 3.

The long list options for a new unit did not specify a level of security. The project group determined that if a new unit were to be built, the unit should be a medium security level. A medium secure unit provides the greatest flexibility for the provision of care at the Mason Clinic, as services can be provided to minimum secure patients in a medium secure facility, but the reverse is not true.

The proposal to build a medium secure unit is supported by the master plan. Firstly, the proposed location for the new building is in the medium / high secure zone on campus and supports the development of non-core forensic services at the Mason Clinic. Secondly, the next building requiring remediation after Tanekaha is Rata which is a medium secure unit. If Tanekaha is built as a minimum secure unit and Rata is decanted into the decant 15 bed secure unit then there is no on-site capability to rehouse patients to facilities above minimum secure levels which does not mitigate the risk to the continuity of service at Mason Clinic. This approach provides alignment with the master plan as well as a risk mitigation for the remediation program. Thirdly, this option supports delivery of the correct number of beds at each security level in line projections under the proposed master plan.

The patients in a number of the worst affected buildings need to be housed in medium security buildings due to their legal status and assessed risk, and they cannot be moved from the Mason Clinic without an application to the Courts. In addition, the prospect of medium security clients detained under the Mental Health Act being transferred to other properties during the remediation works runs the almost certain risk of intense public scrutiny and possible reputational risk. Therefore, construction of a medium secure unit provides insurance in the situation where a medium secure unit fails and patients can be moved to the new unit without delay or major

Tanekaha Unit Not fit for Purpose Replacement Project

reallocation of patients between medium and minimum secure units. In this regard, short-listed options for a new unit specify a medium security level to ensure the continuity of service at the Mason Clinic.

The use of a medium security solution does not involve any higher costs in total over the broader campus redevelopment than would be the case if a minimum security solution was adopted in this case.

The project group also agreed to retain a do-minimum option as a comparator. A do-nothing option is not appropriate due to the risk to continuity of services. Tanekaha is failing and requires remedial work to enable it to be available for clinical purposes in the future. We consider the remediate option is a do-minimum option, doing only what is necessary to keep Tanekaha operational.

A multi-criteria analysis of the shorted listed options was completed, with the assessment based on a set of critical success factors for the project. This is outlined in Table 1 below.

Table 1 Multi criteria assessment of the short listed options against critical success factors

Description of critical success factors	Options			
	Option 0 Remediate	Option 1 New build replacing Tanekaha	Option 2 New build elsewhere on Mason Clinic campus	Option 3 New build on greenfield land
Strategic fit and business needs				
Safe and efficient care delivered via recommended model of care	✓	✓✓✓	✓✓✓	✓✓✓
Enables emergency care options	xxx	xxx	✓✓✓	xxx
Avoids disruption to current services	✓✓	✓✓	✓	✓✓
Provides all forensic services in one location, consistent with recommended model of care and Master Planning for the site	✓✓	✓✓	✓✓✓	x
Security level for the unit provides flexibility to meet Master Plan and long term provision of services	x	✓	✓✓✓	✓✓✓
Staff satisfaction	✓	✓✓	✓✓	xx
Potential affordability (including potential value for money)				
Affordability (excluding cost of land)	✓✓	✓✓	✓✓	xxx
Potential achievability				
Consenting process	✓	✓✓	✓✓	xxx
Time to completion	x	✓	✓✓	xxx
Supplier capacity	✓	✓	✓	✓

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1.4.3 The preferred option

The preferred option (option 2) is to construct a new 15 bed medium secure unit at the Mason Clinic campus (but not on the existing Tanekaha site). It is the preferred option because on balance and in comparison to the other options, it:

- delivers services in line with the recommended model of care
- enables emergency care options
- keeps all forensic services in one location
- provides flexibility in order to align with the master planning for the campus and supports the long term provision of services
- provides flexibility in the security level to act as a back-up in the scenario a medium secure unit fails (minimum services can be provided in a medium secure environment, but not vice versa)
- is expected to be achievable and implementable.

1.5 Benefits and costs

1.5.1 Benefits of the proposed investment

The main benefits of the proposed investment relate to the improved quality of the regional forensic psychiatry services by being fit for purpose facilities aligning to the recommended model of care. The construction of a new unit reduces the risk of a break in the continuity of services at the Mason Clinic, ensuring that the services are sustainable in the long run.

The proposed investment also provides a safe environment for the clinical services. The current risks to human health (to patients and staff) as a result of weather tightness and leaky building issues will be resolved.

There are additional benefits with a new build on Mason Clinic campus (but not on the Tanekaha site). Tanekaha could be used as emergency space and this location is expected to be flexible to meet the long term plan for the Mason Clinic campus.

1.5.2 Costs of the proposed investment

The capital investment required for the options is outlined in Table 2 below, with the preferred option (option 2) requiring an estimated \$17.5m investment (including contingencies). The remediate option requires less capital investment and on-going operation costs, but it is not expected to provide the same level of benefits as new build options. Option 2 is expected to cost more than a new build on the Tanekaha site but does not provide the flexibility for Tanekaha to be used as emergency space during the remediation programme. Option 2 is expected to be financially viable within current operational funding envelopes.

As all operational expenditure is being funded from within existing allocations, no new operation cost expenditure is being sought. The investment proposal is for the capital costs only. The building maintenance cost for each of the options is expected to be funded by using the existing maintenance costs for Tanekaha. The building maintenance costs are expected to be lower than the existing maintenance costs for Tanekaha, so they represent cost savings.

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A key assumption for Option 3 is that the cost of the land is not included in this assessment. If a new greenfield site is selected, Waitemata DHB will purchase land and the cost of the acquisition will be included in the programme business case for the Mason Clinic master plan. The land cost will be determined once the site is identified. It is also assumed that if Option 3 were selected, there would be additional costs to remediate Tanekaha in the short term. It is expected that due to the long length of time which is expected before Option 3 is operational, Tanekaha will be forced to close during that timeframe without remedial work.

Table 2 Cost summary

	Option 0 ¹ Remediate	Option 1 New build replacing Tanekaha	Option 2 New build elsewhere on Mason Clinic campus	Option 3 New build on greenfield land
Construction capital investment (without contingencies)	\$13.0m	\$16.0m	\$16.0m	\$17.1m
Short term remediation cost	N/A	N/A	N/A	\$7.8m
Total construction capital investment required (including contingencies @ 10%)	\$14.3m	\$17.5m	\$17.5m	\$27.4m
Annual operating costs	\$4.9m	\$5.4m	\$5.4m	\$5.4m
Building maintenance costs (over 40 years)	\$4.8m	\$3.7m	\$3.7m	\$3.7m
Present value of costs over 40 years (whole-of-life cost)	\$83.3m	\$92.9m	\$92.8m	\$76.0m

Source: RLB and Consult QS

Due to the delay in site identification and gaining appropriate consents for Option 3, over a 40 year evaluation period, the building is only operational for 34 years, meanwhile for the other new build options, Options 1 and 2 the new unit is operational for 39 years. This difference drives the change in opex and thus the whole of life costs.

1.6 Key risks and constraints

There are a number of risks which threaten the success of the proposed investment, as outlined in Table 3. The risks which have been identified are routine for construction projects, and as such the risk management strategies are also well established.

¹ Note that this table presents Option 0 as the cost of remediation plus expansion of five beds, to ensure consistency in the dollar values provided and enable a like-for-like comparison of the options.

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Table 3 Risks and risk management strategies

Risk	Risk management approach
Consenting delays for the new building	Comprehensive planning and designing that consider the potential impacts on stakeholders. Obtaining input from stakeholders throughout the design/build process.
Scope change	Strong project manager control. Escalation process for change requests, requiring cost and project impact assessment prior to approval
Delays in approvals (to construction design)	Strong project manager control. Escalation process for change requests, requiring cost and project impact assessment prior to approval.
Construction delays	Planning and design is underway, prior to receiving approvals. Strong project management and penalties for the builders for delays in completion.
Delay in site identification	Effective engagement with stakeholders to manage impacts/appeals during consenting process.
Delay in master planning	Frequent and continual engagement with the project steering group which will have oversight of the master planning process for the Mason Clinic.

The outcome of the master planning process is a key dependency for the project. There is uncertainty around whether the Mason Clinic will be allocated additional land (and the location of that land) which impacts the land use of the Mason Clinic. If the Mason Clinic is not given any additional land, and services must be contained within the existing site, there may be a requirement to re-configure the site. For example, Waitemata DHB will have to reconsider the location of planned car parking if it must stay within its current campus boundaries with no additional land.

1.7 Implementation strategy

1.7.1 Procurement strategy

Six procurement options were assessed to identify the most appropriate method, given the current market conditions and context of this project.

It was considered important for Waitemata DHB to retain design control in the context of the build of health facilities, as the clinical perspective is imperative for the new unit. It is also recognised that the construction of a new 15 bed medium secure unit is in the context of the master planning process, which is expected to provide a standard design for each of the units, with some minor configuration to the design as necessary.

The units are expected to be completed sequentially, and as such, a design bid build (DBB) approach would typically be appropriate for construction of a new unit. However, given the current resource

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constraints of the construction market, an Early Contractor Involvement (ECI) arrangement is considered appropriate as part of a wider strategy for the redevelopment. Strong demand for construction means it is more difficult to source materials and secure subcontractors, early identification of these is essential. As such, it is assessed that an appropriate procurement strategy will include ECI contractors involved in pre-construction and design, with a routine competitive bid/build phase following.

1.7.2 Timeframe

It is expected that the facility will be operational from September 2018, in line with the timeline below.

Table 4 *Timeframe for construction of a new 15 bed medium secure unit*

Key Milestones	End Date
Business Case approval	March 2017
Design	July 2017
Tender	August 2017
Building consent	August 2017
Construction period	August 2017 to September 2018
Commissioning	September 2018
Facility operational	September 2018

1.8 Conclusion and recommendation

1.8.1 Conclusion

The Tanekaha unit is failing as it suffers from weather tightness and “leaky building” issues, posing severe risks to the health of patients and staff. It is expected that without remedial works, Tanekaha will have to be closed in the future, which poses a risk to providing services to current patients and a risk of a break in the continuity of providing services at the Mason Clinic in the future. A growing prison muster means that the outcome of a break in the continuity of regional forensic psychiatry services is expected to be more pronounced in the future. Waitemata DHB considers that this risk is unacceptable.

The proposed investment involves constructing a new 15 bed medium secure unit on the Mason Clinic campus (but not on the Tanekaha site). It is considered that this would provide an immediate solution to the failing Tanekaha unit, meet the recommended model of care, provide sufficient flexibility to be consistent with the long term master planning for the Mason Clinic campus, and provide for continuity of services.

1.8.2 Recommendation

It is recommended that the Ministry of Health’s Capital Investment Committee approves total capital costs of \$17.5m to construct a new 15 bed medium secure unit.

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2. Introduction

Waitemata District Health Board (DHB) has prepared this business case for a solution to remedy a failing unit (Tanekaha) at the Mason Clinic. A plan is currently being prepared for a wider redevelopment of the Mason Clinic campus (the master plan for the campus) but it not due to be completed until 2017. However, due to the risk to the continuity of service provision, it is considered that a solution must be found for Tanekaha now.

This single stage business case is prepared in accordance with Treasury's Better Business Case Guidelines.

A Single Stage Business Case is appropriate for the proposed investment, because:

- The capital expenditure for the preferred solution is relatively small. The capital investment is expected to be around \$17.5m, funded from new Crown funding. Existing operational expenditure is expected to be diverted to the solution. New operational expenditure is expected to be small relative to the up-front investment required.
- The project is low risk. The proposed investment enables the services to continue to be provided – the proposed investment does not materially change in the scope of services at the Mason Clinic.

The rest of this business case follows the standard business case structure, with the following five cases:

- strategic,
- economic,
- commercial,
- financial, and
- management case.

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3. Strategic Case

This section provides background information on the business case, setting out the context for change and the drivers for the proposed investment. This section also outlines the key benefits, risks, constraints and dependencies for the proposed investment.

3.1 Background

3.1.1 Purpose of Waitemata DHB

Waitemata DHB primarily serves the communities of Rodney, North Shore and Waitakere. It has the largest and fastest growing population among DHBs in NZ with 580,000 residents and expecting population growth of 18% by 2025².

Waitemata DHB provides secondary hospital and community services from North Shore and Waitakere hospitals, and an additional 30 community centres throughout the district, including the Mason Clinic. It provides specialist services in child disability, forensic psychiatry, alcohol & drug and dental and oral health for pre-school and school students (years 1 – 8), sometimes on behalf of other DHBs across New Zealand.

The purpose of Waitemata DHB is to³:

- Prevent, ameliorate and cure ill health
- Promote wellness
- Relieve suffering of those entrusted to Waitemata DHB's care

In undertaking these activities, Waitemata DHB must balance efficient and effective care to meet local, regional and national needs.

3.1.2 Purpose of the Mason Clinic

Waitemata DHB provides forensic psychiatric services for the Auckland Region, from the Mason Clinic campus located on Carrington Road in Point Chevalier, Auckland. Forensic psychiatric services are provided to Waitemata DHB residents as well as residents of other Northern Region DHBs. The Forensic Intellectual Disability Service on the Mason Clinic campus serves a larger region from Taupo to the top of the North Island.

The Mason Clinic campus comprises ten low rise purpose designed and built clinical buildings. The latest new build opened in 2006, and one new 15 bed medium secure unit is currently under construction. Two buildings have a floor area of approximately 1,500m², three buildings are approximately 1,000m², and the remaining five range in size from 300m² to 500m². Several buildings are of two storeys. The buildings are of mixed material construction, comprising stucco plaster, fibre cement weatherboard and sheet panels, plywood, corrugated iron and concrete block.

It includes eight inpatient units and an intellectual disability unit that assesses, treats and assists in the recovery of people with mental illness or intellectual disability who have committed (or are alleged to have committed) a criminal offence or are at high risk in the community. The inpatient units include open hostel accommodation, minimum security and medium security, with a current capacity of 108 beds.

² Page 6, Waitemata DHB Annual Report 2014/2015

³ Page 12, Waitemata DHB Statement of Intent 2014/2015

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The campus also has non-inpatient units including an Administration Centre (Puriri pod), a Cultural Centre, a Community Outpatient Base (for staff working in Community teams, Courts and Prison Mental health teams), a swimming pool and associated outbuildings all within a single campus of 3.9 hectares. The Mason Clinic facilities are summarised in the Table 5 below.

Table 5 Mason Clinic Facilities

Unit Name	Description
Pohutukawa	12 bed medium secure unit made up of: 10 bed medium secure care and rehabilitation beds 2 medium secure assessment beds Second floor office space for Intellectual Disability Offenders Liaison Service (IDOLS)/ Service Management/ Medical / Quality and Administration team
Tane Whakapiripiri	10 bed minimum secure Kaupapa Maori rehabilitation unit (current capacity is 11 beds)
Tanekaha	10 bed minimum secure rehabilitation unit (current capacity is 12 beds)
Rata	15 bed long term medium secure rehabilitation unit
Kahikatea	20 bed minimum secure rehabilitation unit
Kauri	15 bed medium secure admission units
Totara	15 bed medium secure admission units
Rimu	9 step down bed hostel
Kowhai Building	Office space for Court Liaison and Community Forensic Teams. Also Chaplains and Consumer Advisors.
Puriri Pod	Administration block with Medical Records and Medical Staff
Te Miro	Maori and Pacific Nations Resource Centre, office space for some cultural advisors
New unit currently under construction	15 bed medium secure rehabilitation unit

The key service provided at the Mason Clinic is inpatient assessment and treatment of mentally disordered offenders. The clinic provides integrated forensic mental health services, including assessment and treatment of mentally disordered offenders or alleged offenders as identified in the Northern region's courts, prisons and general mental health services.

Funding for inpatient beds is determined at a national level and allocated regionally in accordance with historical demand forecast by the Ministry of Health (MoH). Demand is so high in the Northern region that the admission of patients from out of region to the Mason Clinic seldom occurs. The length of stay of patients or service users receiving assessment, treatment and rehabilitation ranges from a few days to several years.

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Other Regional Forensic Mental Health Services provided by Waitemata DHB include:

- **Community Forensic Services:** Forensic Consultation Liaison Services are provided to local Mental Health Services regionally and assistance is given in developing and implementing effective plans for risk assessment management. The Forensic Community Team provides clinical care for clients in the “step down” beds; case manages high risk forensic clients in the community and ensures that there is an appropriate transition of clients from the forensic inpatient units to local Mental Health Services.

Twenty step-down beds are provided in the community, in partnership with Non-Governmental Organisations (NGOs):

- 5 Pacific Nations Beds
 - 5 Kaupapa Maori Beds and
 - 10 Mainstream Beds
- **Intellectual Disability Offenders Liaison Service:** This team provides care under the *Intellectual Disability Compulsory Care and Rehabilitation Act 2003*, for people who are referred by the Regional Intellectual Disability Community Care Agency (RIDCA). There is a 12 bed intellectual disability secure unit at the Mason Clinic, one of the two National Intellectual Disability Support Service (NIDSS) units in the country, serving the upper half of the North Island for intellectually disabled offenders. There is also a community Intellectual Disability (ID) liaison team.
 - **Court Liaison Team:** This team has a presence in every major Court in the Auckland and Northland regions. Its primary functions are to provide psychiatric assessment and informal advice to the Court on the appropriateness of formal psychiatric reports and/or diversion to Mental Health Services.
 - **Forensic Prison Team:** This multi-disciplinary team provides tertiary clinical services into prisons. The team manages an inmate caseload, receives referrals from Prison Health Services and facilitates the transfer of mentally unwell inmates to hospital for care and treatment.

3.2 Case for change

3.2.1 Problems with the current Mason Clinic campus

There are two issues that need to be addressed to ensure that the Mason Clinic can deliver services efficiently and effectively. First, the majority of buildings suffer from weather tightness and “leaky building” issues. Second, the configuration of the campus and the units on the campus is no longer consistent with the recommended model of care.

Weather tightness and leaking building issues

As stated above, the Mason Clinic buildings are of mixed material construction, comprising stucco plaster, fibre cement weatherboard and sheet panels, plywood, corrugated iron and concrete block. An assessment of the campus in early 2011 identified that several buildings were failing significantly, suffering from leaking roofs, guttering and exterior walls. An expert building survey was carried out by Cove Kinloch to provide a report on what has now become a “leaking building” situation affecting almost all the buildings to varying degrees.

Water ingress had been, and is, causing internal damage and compromising the integrity of the buildings. Three units have deteriorated to the point where they are at risk of developing

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*Stachybotrys*⁴ fungus in some wall cavities. *Stachybotrys* is a highly dangerous fungus with the potential to cause serious health problems.

Six monthly testing continues. Recent tests confirmed that the presence of the fungus is minimal and currently at safe levels. However, due to the lack of weather tightness of the buildings this situation may not continue, and higher readings could require immediate decanting of one or more of the units.

The weather tightness issues create an unacceptable risk to clients, clients' families and staff health. This could render the buildings unfit for use, threatening the continued ability to provide forensic mental health services. Waitemata DHB considers that the risk that a building could become unfit for use is too great for services to continue to be provided without any resolution of this problem. The buildings require major refurbishment and remedial works to make them fit for purpose and eliminate risk to patient and staff health and safety.

Waitemata DHB determined that a programme of remedial works was required. To support that, a new 15 bed unit under construction will assist with a sequential decanting process while the leaky and weather tightness issues for each unit are addressed.

Model of care

The Mason Clinic's current campus covers approximately 3.9 hectares and sits between the Unitec campus and Oakley Creek in Auckland. The Mason Clinic has a long history at its current campus, with Mental Health services having been provided at Point Chevalier for about 150 years.⁵ The services and supporting infrastructure have evolved over time – the current suite of buildings on the campus are between 8 and 22 years old.

The Mason campus has evolved and grown in a piecemeal way over the last 22 years and it is considered that the campus no longer meets the recommended model of care (consistent with best practice).

First, the existing layout of the campus is not optimally configured. The physical location of the units do not optimally meet the needs of the Mason Clinic, particularly if residential housing replaces the parklands surrounding the Mason Clinic's current environs. For example, the relative locations of minimum and medium secure units on the site will not meet the desired future layout which would provide better clinical and administrative outcomes both for the Mason Clinic and the surrounding community.

Second, the (internal) configuration of the units no longer meet recommended models of care. The number of beds in each unit at the Mason Clinic is a mixture of 10, 15 and 20 bed units, while (as explained in more detail below) the recommended model of care is for 15 bed units. In addition, the units do not have en-suites which are also a component of the modern recommended model of

⁴ *Stachybotrys* is one of the most infamous toxic mould that can grow in houses and is extremely dangerous to humans. It can cause respiratory problems, skin inflammation, haemorrhage, damage to internal organs, mental impairment, irritation of mucous membranes, tiredness, nausea and immune system suppression.

⁵ <http://www.waitematadhb.govt.nz/dhb-planning/waitemata-2025/upcoming-projects/mason-clinic/>

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care, seclusion areas in minimum secure units are no longer needed, and some units have manifestly inadequate space to facilitate the recovery of service users who may spend years living inside these units.

3.2.2 Campus-wide redevelopment of the Mason Clinic

Waitemata DHB is preparing a long term master plan for the Mason Clinic campus. Driven by an expected increase in the demand for forensic mental health services, remediation works for the existing buildings, and broader consideration of the site vis-à-vis the redevelopment of the Unitec campus, Waitemata DHB in conjunction with the MoH and Treasury are revisiting the overall plans for the site. Waitemata DHB, MoH and Treasury are considering options to meet changing needs and failing infrastructure to deliver health services.

The master plan is under development, and is expected to be completed and agreed with project stakeholders by February 2017. At the same time, the Crown through MBIE is also embarking on a long term plan for the Unitec campus, which will influence the master plan for the Mason Clinic (discussed in further detail below).

The master plan for the Mason Clinic site will be broad and includes the location of Regional Forensic Psychiatry Services. There are three location options for the Mason Clinic master plan:

- Option A) Remain on Carrington Road site with no additional land
- Option B) Remain on Carrington Road site with 2.2 ha of additional land
- Option C) Move to a green field site local to the Mason Clinic site area.

Appendix 7 of the Master Planning Design Report (October 2016 version) outlines the current master plan for the Mason Clinic campus including the specifications for Options A, B and C above.

The master plan for the Mason Clinic campus also involves a wide range of planning activities to ensure that the services provided deliver positive health outcomes for patients, maximise possible resources and are delivered in safe buildings. In this regard, the master plan encompasses:

- Remediation works on existing buildings, to address weather tightness issues (three to five year programme)
- Ensuring capacity to meet expanding demand for services over time
- Upgrading facilities in line with current recommendations for the model of care (e.g. 15 beds per unit, en-suites to bedrooms, sufficient gross floor area (GFA) to enable the delivery of rehabilitative programmes while generally providing safe and appropriate care to service users, no seclusion rooms for minimum secure units).

In addition to meeting the immediate need for remediation works due to weather tightness issues in the current buildings and expansion of forensic psychiatric services, redevelopment of the campus provides Waitemata DHB, MoH and Treasury the opportunity to reconfigure the site, in line with the redevelopment plans for the Unitec campus.

Unitec is considering its long term plans for the Carrington Road campus, the outcome of which will have an impact on the master planning process for the Mason Clinic. Unitec is considering redeveloping its campus, focusing on concentrating learning areas in the southern end of the campus and surrounding them with green space, public parks and residential housing. MBIE is also a

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stakeholder for the Unitec redevelopment, as the Crown owns the land on which the campus currently sits and there is a need to increase housing supply in Auckland.

The plans for the Unitec campus strongly influence the master plan for the Mason Clinic. For example, the land use around the Unitec campus will determine the design requirements for the Mason Clinic master plan. If the land adjacent to the Mason Clinic were redeveloped for housing, the Mason Clinic campus master plan would specify a layout that provides a sense of security without a physical barrier around the campus' perimeter and protects the privacy of both the Mason Clinic's patients and residents.

The master plan will influence the Tanekaha solution through a number of mechanisms, as outlined in Table 6.

Table 6 How the master plan influences the Tanekaha solution

Factor	Description
Land use around the campus determines design requirements	If Unitec develops the surrounding area for housing, the campus layout needs to be made in a manner that provides a sense of a security barrier without actual perimeter security fencing, and which limits the view into the units whilst maximising the unit open spaces. In this regard, unit orientation and layout is important.
Land availability determines building type to be built	If additional land is available for the Mason Clinic, the site will be developed for core forensic and non-core forensic services on the same site. Separation of the services and access to the services is critical, e.g. high security adults should be separated from low security adults and both separated from youth services and high and complex needs patients.
Master Plan determines bed numbers in Tanekaha unit	Based on Mason Clinic service experience and national feedback the recommended number of beds per unit for the most efficient operation and best model of care is 15 beds per unit. Tanekaha has 10 beds and Kahikatea has 20 beds. A solution as part of the Mason Clinic master plan would support rationalisation of the bed numbers to 15 beds per unit (including Tanekaha) resulting in the same overall number of beds but better alignment to the recommended model of care.
Master Plan determines the security level for the proposed Tanekaha replacement	Based on the development of co-located core and non-core forensic services at Mason Clinic campus, the master plan calls for medium and high secure adult units to be located in the northern part of the campus and low secure and youth services to be located in the southern part of the campus to keep the services separate. The available location for a new unit on the existing Mason Clinic campus land is in the north side of the campus which determines that a medium or high secure unit should be built for the Tanekaha solution if a

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Factor	Description
	new build is preferred. The final low security replacement would be built in the southern side of the campus as part of the master plan program.
MBIE option determines most appropriate remediation approach, minimal remediation or rebuild	If MBIE's recommendation is for Waitemata DHB to move the Mason Clinic to a new site then the most appropriate solution for Tanekaha would be a minimal remediation to hold the building over for another 5 years while a new offsite facility is developed.

In addition to meeting immediate needs to remediate failing buildings and clinical benefits associated with employing the recommended model of care, the master planning process can optimise the location of administrative and communal areas, providing administrative benefits to Waitemata DHB.

3.2.3 The problem now - the Tanekaha unit is failing

The Tanekaha unit is a priority unit for remediation. Without remedial works, the Tanekaha unit is not expected to be habitable in the near future, posing risks to patient and staff health. As such, addressing the failing unit is deemed as urgent and action cannot wait until after the master planning for the site is complete.

In September 2016, an Investment Logic Mapping (ILM) process was undertaken to help stakeholders define the key problems faced by providing forensic psychiatric services at the Mason Clinic, and specifically providing services in the Tanekaha unit. The ILM was subsequently revised in November 2016, to reflect the common understanding of the problem, and feedback from MoH and Treasury. These problems are summarised below (Table 7) and the ILM is attached as Appendix 1.

Table 7 Tanekaha unit problem definition

Urgent problems with Tanekaha	
Increasing exposure to environmental hazards is heightening the risk of serious harm to patients and staff	As discussed in 3.2.1, the Tanekaha unit is failing and the level of toxic mould is expected increase to an unacceptable level, posing a risk of harm to patients and staff.
Inability of Tanekaha building to optimally deliver recommended model of care, due to building being not fit-for-purpose and an inefficient configuration	As discussed in 3.2.1, the Tanekaha unit is not optimally configured to provide the recommended model of care for patients.
Ongoing deterioration of Tanekaha threatens viability of campus service continuity	The level of toxic mould is expected to increase if no remedial work is undertaken, which may lead to the building being closed as it will be hazardous to human health. This will adversely impact the continuity of forensic mental health services for patients in the Auckland

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and Northern regions.

3.3 Strategic alignment

The proposed investment is aligned with national and local objectives for health care in New Zealand and the Northern region, as outlined by level below.

3.3.1 National alignment

The Government, through the Department of Corrections, has the legislative responsibility to keep offenders in prison safe while in the Department's care. The Government recently announced a new \$14million mental health package to better support offenders by providing increased access to mental health services.

A growing prison muster in the Northern Region will flow through to an increase in the number of prisoners with serious mental health needs who require treatment at the Mason Clinic. Mental health disorders and illnesses are up to five times more prevalent among prisoners than the general population.⁶ However, it is hoped that the investment by the Government to improve access to mental health services will reduce the demand for treatment at the Mason Clinic, to some extent.

The proposed investment is aligned to national standards documents, such as the New Zealand Standard Health and Disability Services (Core) Standards.⁷ The requirement to provide a safe and appropriate environment (NZS 8134.1.4) outlines the need for services to be provided in a physical environment which minimises the risk of harm, among other requirements. The proposed investment would meet the New Zealand Building Code standards, which also promote safety.

In addition, the proposed investment considers the quality of life and the ability for the physical environment to influence quality of life. This is consistent with removing an institutional barrier to transforming the mental health system framework for the benefit of service users, as identified in the Destination: Recovery discussion paper.⁸

3.3.2 Regional alignment

The proposed investment is aligned with expectations that Waitemata DHB will continue to be capable of providing regional forensic services from clinically safe and fit-for-purpose facilities. There are limited facilities around New Zealand from which forensic psychiatry services can be provided with Waitemata DHB holding the northern region contract for such services.

The Northern Region, covering the Northland, Waitemata, Auckland and Counties Manukau DHBs has a coordinated approach for delivering services to patients in these areas. This enables the DHBs to strategically provide services to patients while optimising resources in the Northern Region, with consideration given to factors such as:

- Models of care

⁶ http://www.corrections.govt.nz/working_with_offenders/prison_sentences/being_in_prison/health_care.html

⁷ <https://www.health.govt.nz/system/files/documents/pages/81341-2008-nzs-health-and-disability-services-core.pdf>

⁸ <https://www.mentalhealth.org.nz/assets/Our-Work/Destination-Recovery-FINAL-low-res.pdf>

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- Workforce
- Affordability
- Capacity.

The Northern Region Health Plan 2015/16, an integrated plan by the Northern Region DHBs, includes goals for mental health and addiction. One of the objectives includes improving the responsiveness of mental health and addiction services for people with high and/or complex needs, many of whom are receiving treatment at the Mason Clinic.

The proposed investment is directly aligned to improving responsiveness of forensic services. As noted in section 3.1, the Mason Clinic provides forensic mental health services to patients in the Auckland region. A solution to remedy the failing Tanekaha unit is required to reduce the risk of a break in the continuity of services to patients across the Region.

3.3.3 Local alignment

Waitemata DHB is planning for the longer term, to ensure the services provided meet the needs of a growing population. The core design principles which flow through to the design of services today and in the future include:

- Inclusive planning and universal design
- Flexible and future-focused design
- Enhanced patient and whānau experiences of services
- Health promoting environments
- Low impact, high efficiency design.

The proposed investment is strongly aligned to the principles of enhanced patient and whānau experiences of services; health promoting environments; and low impact, high efficiency design. The Tanekaha unit is currently in a poor condition and is failing. A solution to remedy the issue will enhance the patient experience, which will be provided in a health promoting environment (or reverse the status quo's negative impacts on health).

Waitemata DHB provides specialist regional forensic psychiatry services to meet the health needs of people with significant mental health needs, who are before the Courts or who are in the criminal justice system. The proposed new build would increase the Mason Clinic's ability to provide high-quality services in an environment which is secure and safe.

Waitemata DHB's Annual Plan 2016/17 outlines goals to reduce morbidity and mortality for people with mental illness⁹⁹, which the proposed investment will support by ensuring high quality services in a safe environment.

3.4 The proposed investment

The proposed investment is a solution to address the urgent weather tightness issues of the Tanekaha unit. It is also consistent with the master planning for the Mason Clinic which is currently underway. The proposed solution also needs to be flexible enough to ensure that long term planning for the site can be accommodated once the plans are agreed by Waitemata DHB, MoH and Treasury.

⁹⁹ <http://www.waitematah.govt.nz/assets/Documents/annual-plan/Waitemata-DHB-Annual-Plan-2016-17.pdf>

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3.4.1 Investment objectives

The investment objectives (in Table 8) of the proposed investment are aligned to the most pressing business needs. These include weather tightness issues and the ability of the accommodation to provide the recommended model of care.

Table 8 *Investment Objectives*

To support the improvement in overall regional forensic psychiatry services building quality	
Existing arrangements	<ul style="list-style-type: none"> Urgent remediation is required to buildings with weather tightness issues Patients are accommodated in poor quality residential units, creating health and safety risks Staff are providing services in poor quality units, creating Health and Safety risks
Business needs	<ul style="list-style-type: none"> Service provision in facilities without health and safety concerns Medium secure facility with sufficient capacity to accommodate 15 patients Building that enables the provision of the recommended model of care Provide flexibility in the remedial works for Tanekaha to ensure that long term planning (master planning for the campus) can be accommodated Ensure remedial construction work is not duplicated over the short to medium term (i.e. minimise costs of remedial works on Tanekaha now and further construction on Tanekaha in the future)

3.4.2 Key benefits

The key benefits from the proposed investment relate to providing services in a safe environment, and following the recommended model of care across campus:

- Safe environment for patients and staff
- Provision of safe and effective care, reducing the risk of avoidable harm
- Sustainable, resilient, high quality services which meet the needs of patients
- Flexibility to support the recommended model of care across campus.

Waitemata DHB has legal obligations as an employer to comply with the Health and Safety at Work Act 2015, ensuring that workers should be given a high level of protection against harm to their health, safety, and welfare from work risks as is reasonably practicable. It is also essential to ensure that services are provided to patients in, and staff work in, a safe environment which does not pose unreasonable risks to their health.

An indicative benefits map is included in Appendix 2.

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3.5 Key risks

The key risks for the proposed investment are outlined in Table 9. Some risks have outcomes which are more significant than others. An assessment of the significant level of each risk is provided in Table 9.

Table 9 Key risks

Risk	Description	Significance level	Significance level description
Consenting delays	Consenting process for building a new unit not at the Mason Clinic site may pose a risk to the design/build timeline, cost or both. This could potentially delay the availability of new facilities.	Medium	<p>These are routine risks, often observed in construction projects. They are assessed as being manageable (see table below for risk management strategies).</p> <p>Clinical services will still be provided in the short term from Tanekaha. In the medium term, clinical services will be provided from refurbished or new facilities.</p>
Scope change	Waitemata DHB initiated scope changes post contract award increases design/build timeline, cost or both. This would delay decanting, impacting the project timeline.		
Delays in approvals (to changes in construction design or investment approval)	Delay in receiving approvals results in an extended timeline, impacting ability to remediate Tanekaha.		
Construction delays	Time to build exceeds expected timeline, impacting ability to commence and complete decanting from Tanekaha.		
Delay in site identification	Delays in finding an appropriate site for the proposed investment.	High	<p>These risks are specific to the Mason Clinic and remediation of Tanekaha.</p> <p>The level of complexity for these two risks is high, given the multi-party involvement. Therefore, the risk of a delay is much higher than other risks, potentially posing a threat to the long term provision of services in suitable accommodation. .</p>
Delay in master planning	Uncertainty around the long term planning and use of the Mason Clinic site could lead to duplication of effort and duplication of resources invested into remediation of Tanekaha.		

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The following risk management strategies in Table 10 can be employed.

Table 10 Risk mitigations

Risk	Risk management approach
Consenting delays	Comprehensive planning and designing that consider the potential impacts on stakeholders. Obtaining input from stakeholders throughout the design/build process
Scope change	Strong project manager control. Process to determine the requirements prior to awarding the contract. Escalation process for change requests, requiring cost and project impact assessment prior to approval
Delays in approvals (to construction design or investment approval)	Strong project manager control. Escalation process for change requests, requiring cost and project impact assessment prior to approval
Construction delays	Planning and design is underway, prior to receiving approvals. Strong project management and penalties for the builders for delays in completion (although this depends on the nature of the contract ultimately used)
Delay in site identification	Effective engagement with stakeholders to manage impacts/appeals during consenting process
Delay in master planning	Frequent and continual contact with the project steering group which will have oversight of the master planning process for the Mason Clinic. Master planning process cognisant of dependencies regarding this project.

3.6 Key constraints and dependencies

The project faces a number of constraints and dependencies that have the potential to impact multiple aspects of the project including overall cost and completion time. The main project dependencies are included in Table 11.

Table 11 Project dependencies

Project Dependencies	Description
Master planning	The overall location of the Mason Clinic may change which could impact the range of services and where the services are provided e.g. the location of car parking will be dependent on which option is provided for the site (stay within current site, expansion by 2.2ha or a new greenfield site)

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Project Dependencies	Description
Resolution of car parking requirements	The parking requirements in the Proposed Auckland Unitary Plan may require more car parking than desired by Waitemata DHB, which influences the overall cost of the project
Identification of site at Carrington or greenfield site	The complexity and scale of this project, as well as the consenting process can also be impacted by the site selection results
Consenting process	Implementation of the master plan may also be impacted by the consenting process, contingent on the support of residents in the area as well as the potential environmental impacts
Budget/cost	The project is dependent on gaining approval for funding before it can proceed
Staff input	Working environment and safety arrangements will directly impact staff satisfaction and retention, therefore it is important to consider staff preferences
Patient input	Project selection directly impacts quality of care and facilities enjoyed by patients. Thus it is important to consider patient requests and feedback
Level of care required/achievable	Of the options considered in the Economic Case, different options may provide different levels of care and patient benefit.

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4. Economic case

This section outlines the process to identify options to meet the project and investment needs. It sets out the analysis which has been completed to identify a preferred solution.

4.1 Critical success factors

The critical success factors (CSFs) agreed by the project working group for the proposed investment are summarised in Table 12. The proposed investment should align with these CSFs.

Table 12 *Critical success factors*

Critical success factor	Sub-factor	Considerations
Strategic fit and business needs	Safe and efficient care delivered via recommended model of care	<ul style="list-style-type: none"> Increased flexibility in design of the environment to enable patient-centric model of care improvements
	Enables emergency care options	<ul style="list-style-type: none"> Meets wider regional mental health needs Meets wider forensic mental health needs Provide option for emergency care
	Avoids disruption to current services	<ul style="list-style-type: none"> Maintaining minimum service and quality levels Key staff available and capable of implementing the solution
	Provides all forensic services in one location, in line with recommended model of care and Master Planning for the site	<ul style="list-style-type: none"> Flexibility for future use and contributes to long-term Waitemata DHB and regional capacity plans Meets wider regional mental health needs Meets wider forensic mental health needs
	Security level for the unit provides flexibility to meet Master Plan and long term provision of services	<ul style="list-style-type: none"> Alignment with longer term service and site planning
	Staff satisfaction	<ul style="list-style-type: none"> Increase service delivery productivity due to fit for purpose clinical space
Affordability (including value for money)	Affordability (excluding cost of land)	<ul style="list-style-type: none"> Total upfront capital cost, and whole of life cost, is within approved levels In line with (able to be accommodated in) the Long Term Investment Plan Whole of life cost is minimised
Achievability	Supplier capacity and capability	<ul style="list-style-type: none"> Architects, builders/other professionals are available to

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Critical success factor	Sub-factor	Considerations
		implement the solution <ul style="list-style-type: none"> Staff capability and capacity to deliver service
	Consenting process	<ul style="list-style-type: none"> The risk involved in delivering the solution is manageable Land is available Consentable and acceptable to the community
	Time to completion	<ul style="list-style-type: none"> Delivers solution in time to meet demand Minimise congestion and disruption to campus during implementation Minimise impact and disruption to service provision

4.2 Long listed options

A long list of options were developed for addressing the issues with the Tanekaha unit. When developing the options, the four themes were considered as stated in Table 13.

Table 13 Options assessed in the long list

Category / Theme	Description	Number of options considered within each theme
Scale & Scope (What)	Options for what the solution could look like	3
Implementation (Timing & Staging)	Options for the timeframe for a solution	2
Service solution (How)	Options for how to resolve the problem	17
Service Delivery (Who)	Options for who could deliver the solution	4

The 17 options for the service solutions covered a range of features, including:

- The level of permanency (e.g. temporary repairs, permanent repairs)
- The type of physical solution (e.g. repair, remediate or a new building)
- The size of a new unit (e.g. same size or expanded capacity)
- The location of a new unit (e.g. same site at Tanekaha, different location on-site, different site)
- Utilisation of existing resources (e.g. repurposing an existing building).

The service solution options did not specify a security level for any of the new builds.

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4.2.1 Long list options analysis

A high level multi-criteria analysis of the long list of options for remediating Tanekaha was undertaken. The options were assessed against a set of criteria, as outlined in Table 14, with equal weighting for each criteria.

Table 14 *Criteria used for the long list assessment*

Criteria
Solution must be in place urgently
Meets overall capacity requirements
Solution must be the end solution, or must be able to be sustained until the end solution is in place
Value for money, minimises sunk costs
Strategic Fit & business needs
Supplier capacity and capability
Affordability
Achievability
Summary

The details of the assessment is included in Appendix 3.

The working group's preferred service solution was for a new building at the Mason Clinic (but not on the existing Tanekaha site), with an expanded number of beds.

One notable element of this assessment is that a larger solution to the existing Tanekaha unit was preferred to a same-size solution. A 15 bed unit is consistent with the current recommended model of care, as opposed to the current 10 bed. This will also allow the reduction of the Kahikatea unit from 20 beds to 15 as part of the wider campus redevelopment, which will be consistent with moving toward the current recommended model of care.

4.3 Short listed options

Waitemata DHB refined its understanding of the options to find a solution for Tanekaha in the context of the master planning and knowledge of Tanekaha, as well as better understanding of the broader remedial programme.

A previous business case for a new 15 bed medium secure unit was approved by the Capital Investment Committee (CIC) in 2015, which was to support forecast growth in demand for mental health services at the Mason Clinic and to support the remedial programme. It was initially envisaged that the new unit would support sequential decanting. Patients would move into the new unit, while their home unit was being remediated.

However, as Waitemata DHB gained further insight on the remediation works, it was discovered that the cost of remediation was not much less than construction of a new building, while the new building provided additional clinical benefits to patients, such as providing services in line with the recommended model of care. As a consequence, the previous plan to sequentially remediate the failing units was no longer deemed appropriate given the opportunities provided by a new unit.

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The master planning for the Mason Clinic is not yet finalised, so the location of the unit is uncertain. For the purposes of this business case, the project group agreed to have three location variants for the new unit's:

- the same site as the current Tanekaha unit
- a different site to Tanekaha but at the Mason Clinic
- a new greenfield site (not on the Mason Clinic site)

While the master planning process is on-going, the fundamental drivers for this business case are well established and will not change. Further refinement of the master planning will not compromise the proposed options. As the planning process has progressed, a site for a new unit (if the Mason Clinic is not able to acquire new land) has been identified.

The long list options for a new unit did not specify a level of security. The project group determined that if a new unit were to be built, the unit should be a medium security level. A medium secure unit provides the greatest flexibility for the provision of care at the Mason Clinic, as services can be provided to minimum secure patients in a medium secure facility, but the reverse is not true. In addition, due to the nature of the crimes patients in medium secure units have committed, or are alleged to have committed, they cannot be moved from the Mason Clinic without an application to the Courts. The public perception and reputation risk involved in having medium security patients transferred to other properties during the remediation process, supports having an additional medium secure unit on site. As such, construction of a medium secure unit provides insurance in the situation where a medium secure unit fails, as patients can be moved to the new unit without delay or major reallocation of patients between medium and minimum units. Therefore the project group agreed that the short-listed options for a new unit specify a medium security level.

The project group also agreed to retain a do minimum comparator. A do-nothing option is not appropriate due to the risk to continuity of services. Tanekaha is failing and requires remedial work to enable it to be available for clinical purposes in the future. As such, the do-nothing option is amended to a do-minimum option, which involves refurbishment (e.g. re-cladding) and like-for-like remedial works.

The short listed options are set out in Table 15.

Table 15 Description and key features of the options

Option	Description	Features
0	Remediation of the existing Tanekaha unit	<ul style="list-style-type: none"> • This is the do-minimum • A remediation of the existing unit, to a like-for-like state • This will either not allow Kahikatea to be reduced to 15 beds (as expected under the wider campus redevelopment), or if Kahikatea is reduced to 15 beds then it will require an additional 5 beds to be included somewhere else on the campus.

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Option	Description	Features
1	New build on the existing Tanekaha site	<ul style="list-style-type: none"> Existing Tanekaha building is demolished A new 15 bed, medium security, unit is developed on the same site GFA of 1700m²
2	New build at Carrington but not on the existing Tanekaha site	<ul style="list-style-type: none"> A new 15 bed, medium security, unit is developed elsewhere on the Mason campus GFA of 1700m² Existing Tanekaha building is only used for emergency purposes in the future
3	New build on greenfield land (not on existing Carrington site)	<ul style="list-style-type: none"> A new 15 bed, medium security, unit is developed on a new greenfield site (not at Mason clinic campus) GFA of 1700m² Existing Tanekaha building is only used for emergency purposes in the future. Due to the long timeframe for this option, it is expected that remedial work on Tanekaha would still be required.

Further planning has occurred since the options were originally identified. There has now been a site identified for the new building, which will be the same regardless of if the plan is to stay on the existing Mason Clinic site footprint, or to expand onto additional land, and a location for car parking has been identified. The revised Options 1 and 2 are included as Appendix 6. We note that this Option 2 is slightly different to that shown in the latest Master Plan document in Appendix 7.

4.4 Assessment of short listed options

4.4.1 Short list options analysis

The project group undertook a multi-criteria analysis of each short listed option, scoring each of the options against each of the criteria a value between (-3) and (+3). Each of the above options are assessed against a range of critical success factors, the results are shown in Table 16.

Table 16 Multi criteria assessment of the short listed options

Description	Options			
	Option 0	Option 1	Option 2	Option 3
Strategic fit and business needs				
Safe and efficient care delivered via recommended model of care	✓	✓✓✓	✓✓✓	✓✓✓
Enables emergency care options	xxx	xxx	✓✓✓	xxx
Avoids disruption to current services	✓✓	✓✓	✓	✓✓

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Provides all forensic services in one location, consistent with recommended model of care and Master Planning for the site	✓✓	✓✓	✓✓✓	✗
Security level for the unit provides flexibility to meet Master Plan and long term provision of services	✗	✓	✓✓✓	✓✓✓
Staff satisfaction	✓	✓✓	✓✓	✗✗
Potential affordability (including potential value for money)				
Affordability (excluding cost of land)	✓✓	✓✓	✓✓	✗✗✗
Potential achievability				
Consenting process	✓	✓✓	✓✓	✗✗✗
Time to completion	✗	✓	✓✓	✗✗✗
Supplier capacity	✓	✓	✓	✓

The multi-criteria analysis of the short listed options shows that option 0, remediating Tanekaha, is inferior to new build options, as it will not provide the flexibility to meet the Master Plan and long term provision of services. The remediate option will not provide services in accordance with the recommended model of care, which is expected to be detrimental to the quality of service provided.

The remediate option is also expected to take longer than option 1 or 2 to complete, and does not provide emergency care options (unlike option 2).

Of options for a new build, while option 3 (a new build on a new site) provides services in line with the recommended model of care, it has severe disadvantages compared to options 1 and 2. It is expected to take much longer to implement – identification of a site and the consenting process is expected to be a lengthy process. Due to the long timeframe for completion of option 3, it is expected that Tanekaha will fail and require remedial work in the short term to enable services to be provided from the unit.

In addition, option 3 does not keep all forensic services in one location, which is detrimental to patients and staff and reduces administrative and infrastructure efficiencies.

Option 2 provides similar advantages to option 1, but it provides for emergency care options, and is expected to be completed sooner than option 1, as option 1 requires the demolition of Tanekaha before construction can begin. Due to the need for demolition, the site preparation costs are expected to be greater for option 1 than option 2.

It is clear that option 2 is best aligned with the critical success factors. A new build on the Mason Clinic site enables safe and efficient care delivered throughout the process, as well as enabling emergency care options. This option also keeps disruption to current services to a minimum while providing 15 additional beds after completion of construction. Furthermore, option 2 keeps all forensic services together and is in line with recommended model of care. Additionally, constructing a new building will increase the security level, allowing for more flexibility to meet the Master Plan and long term provision of services.

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Option 2 is also superior for staff satisfaction compared to the alternatives as a new and modern building will provide staff with an improved working environment compared to the remediation option.

It is currently anticipated that the proposed new Type 2 (T2) 15 bed medium secure unit is located to the north east corner of the existing Mason Clinic site. It will occupy the area currently used by the pool and associated buildings. The costs associated with re-developing the site have been included in the financial analysis in section 6. We note that the new unit could be built in an alternative location on the Mason Clinic site, if the master planning process changes the preferred location.

The Mason Clinic Masterplan Rev C dated 18.10.2016 used a generic model for most of the proposed units containing 15 beds and these are approximately 1700sqm GFA. The new proposed T2 unit largely follows the location and size of one of the units indicated in the Masterplan Option 2 - 2.2Ha Expansion on drawing MP011d. It has been designed within the existing Mason Clinic site boundaries to suit the timing of the development ahead of any acquisition of additional land.

The proposed T2 unit has been designed to allow for a future unit to be joined to it at a later date should the northern site be acquired.

A revised concept plan and schedule of accommodation with updated areas are included in Appendix 4.

4.4.2 Main benefits

The preferred option can provide a range of benefits and include:

- Enable decanting for essential remediation works on existing buildings in line with master planning
- Improved service quality
- Safe environment for patients and staff
- Sustainable, high quality service that meets the needs of the population
- Better value from investment

These benefits will allow Waitemata DHB to enhance the service provided to its patients and will enable current issues to be fully addressed. The benefits will contribute to the sustainability of the level of care achievable, thus creating ongoing rewards for the community and stakeholders. Table 17 summarises the project benefits.

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Table 17 Main benefits of the proposed investment

Benefit	Description	Estimated Value
Safe environment for patients and staff	<ul style="list-style-type: none"> Support Waitemata DHB's ability to continue to provide regional forensic mental health services from safe and secure premises; Obligations are met with respect to the Health and Disability Services Act. Obligations are met with respect to the Health and Safety Act 	Not financially quantified
Emergency capacity	<ul style="list-style-type: none"> Existing Tanekaha can be used as emergency space, if it is required in emergency situations 	
Sustainable, high quality service that meets the needs of the population	<ul style="list-style-type: none"> Ensure delivery of sustainable, high quality services that meet the needs of the population. Services are provided according to recommended models of care 	
Improved service quality and clinical benefits	<ul style="list-style-type: none"> Services are provided in a modern fit for purpose building providing improved service quality and potentially improved clinical benefits from the improved environment 	
Flexibility to meet long term plans	<ul style="list-style-type: none"> Flexibility to support long term plans for the Mason Clinic and the provision of forensic mental health services (master planning) 	

4.4.3 Main costs

The preferred option is expected to cost \$17.5m to build, with the majority of the costs due to base building costs. The cost of the preferred option is slightly higher than the 2015 business case to expand the regional forensic psychiatric capacity due to a slightly larger floor area for the preferred option. The increase in size is due to future proofing the unit, reserving gross floor area for a living area.

Table 18 Major cost items for the preferred option¹⁰

Cost item	Estimate
Site prep	(\$15,000)
Infrastructure work	\$385,000
Base building costs	\$12,376,000
External works	\$189,000
On costs	\$0
Fees	\$1,400,000
Cost escalation	\$580,000
Furniture, fixtures and equipment	\$600,000
Information technology costs	\$450,000
Total project contingency @10%	\$1,500,000
Total project cost	\$17,465,000

¹⁰ Total may not add due to rounding

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4.5 Summary of preferred option

A new build at the Mason Clinic but not on the existing Tanekaha site is the preferred option after considering the benefits and costs involved.

This option will construct a new building on the current Mason Clinic site and retaining the existing Tanekaha unit as emergency space. The new building is expected to provide a safe environment for high quality care for patients, and a safe environment for staff. Keeping all forensic services together at the Mason Clinic campus is expected to be in line with the master plan for the campus and the in line with the recommended model of care. An additional benefit is that it allows the existing Tanekaha unit to be available as emergency space.

Additionally, constructing a new building will allow for an increased security level, allowing for more flexibility to meet the Master Plan and long term provision of services. It is also superior for staff satisfaction compared to the alternatives as a new and modern building will provide staff with an improved working environment compared to remediation.

The preferred option is implementable within acceptable timeframes, and is expected to have fewer consenting issues. Due to the cost of demolition, it is expected to be more affordable than construction of the new unit on the existing Tanekaha site.

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5. The Commercial Case

The commercial case sets out the process to procure the proposed investment. This section outlines the options and shows it is commercially viable, and appropriately deals with risk.

5.1 Procurement strategy

Below we outline possible strategies for the procurement of the design, construction, ongoing maintenance and operations of the units.

There is a range of possible procurement models across a spectrum of public and private sector participation with associated risk transfer. These models include:

- **Traditional models:** Waitemata DHB would individually enter into contracts with an expressly identified risk allocation, such as design bid build (DBB), design, construct and maintain (DCM), or design and construction (D&C). The effectiveness of these arrangements tends to rely on the ability of the Waitemata DHB to define its performance requirements prior to tendering and to have a clear identification, understanding and quantification of risks.
- **Relationship based models:** Waitemata DHB would enter into a collaborative relationship agreement with appropriate parties to define requirements, understand risks and undertake the works. These approaches generally collectively share risk on a 'no fault, no blame' basis with incentives built in to equitably share additional or reduced value to Waitemata DHB by outcomes actually achieved, thereby encouraging enhanced performance. Such approaches include the Early Contractor Involvement (ECI) model and Alliance contracting.
- **Privately financed models:** Waitemata DHB would enter into contracts with a fixed risk allocation on a whole-of-life basis, such as public-private partnership (PPP) models.
- **Managing contractor procurement models:** Waitemata DHB would appoint a Managing Contractor as the head contractor who would engage subcontractors on behalf of Waitemata DHB to deliver the works and would typically be paid a management fee and incentive payments for achieving target price, schedule and other key parameters.

Appendix 5 provides a high level summary of the key characteristics of different examples of these models and how they could be applied context of building a new unit.

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Table 19 Procurement methods in construction

Procurement method	Description
Design bid build (DBB)	Waitemata DHB individually contract with separate entities for the design and construction phases of the project for the segments they are responsible for.
Design and construct (D&C)	Waitemata DHB seeks tenders to provide a (typically) fixed price for design and construction.
Design, construct and maintain (DCM)	Contractor retains responsibility for maintenance, but typically these models do not extend beyond the first major lifecycle phase.
Early Contractor Involvement (ECI)	Typically, the preferred ECI contractor is selected under open competition for a whole of project contract (i.e. including design development, design and construction). Typically, agreements are staged, and either a D&C or bid/build contract is entered into with the ECI contractor following the detailed definition phase. A further contract could then be entered into to provide maintenance and (potentially) operations services.
Alliance	An Alliance relationship is formed between key project participants, which include Waitemata DHB and non-owner participants (e.g. designer, constructor, other key stakeholders, etc). The relationship must be collaborative for the Alliance to be effective. Options are available to develop the Target Outturn Cost (TOC) in a competitive environment. However, most alliances have tended to use a single party to develop the TOC. This relies on the owner implementing approaches that create appropriate cost, quality and scope tensions, and the right level of expertise to critically validate the TOC, including risk quantification. A further contract would likely then be entered into to provide maintenance and (potentially) operations services. A key feature of Alliances is the gain share pain share incentive mechanism.
Public Private Partnership (PPP)	Generally, a private sector contractor (or contractor consortium) is responsible for the design, construction, operation, maintenance and finance over an extended period (typically 25-30 years). This is a typical long-term, whole-of-life approach to infrastructure delivery. Risk allocation is determined up front for the period of the contract, including maintaining the infrastructure and providing the services to a pre agreed condition for the duration of the concession. Risk transfer, bundling of whole-of-life costs and incentives from having private finance at risk can drive increased innovation.
Privatisation	Full transfer of rights to the private sector through sale, or a sale and lease back arrangement.

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5.2 Assessment

Waitemata DHB has not conducted market sounding with regards to this project, but it has recently completed a procurement process for the construction of a new 15 bed medium secure unit, which is currently under construction. The assessment has been completed with this recent experience in mind, as well as in the context of the construction required to redevelop the campus in line with the master planning.

The design bid build (DBB) option appears to be most suited for the project after careful consideration of the complexity, size, risks, costs and scope of the project. Construction of a new unit is routine and the level of complexity is low, meaning the more novel procurement models are not necessary. Table 20 summarises the suitability of each of the procurement options considered above.

Table 20 *Feasibility and suitability of different procurement options*

Option	Comment	Feasibility / suitability
Design bid build (DBB)	Traditional procurement model. Widely recognised and understood. Commonly used for this type of project.	Yes
Design and construct (D&C)	Traditional procurement model. Widely recognised and understood. Commonly used for this type of project.	Unlikely
Design, construct and maintain (DCM)	Less common than above models, but still well understood and applicable to this type of construction project.	Unlikely
Early contractor involvement (ECI)	Generally suited to complex projects where the cost, risks and scope are difficult to define upfront, making a standard construction tender process difficult. This is a reasonably standard construction project, meaning ECI is unlikely to be suitable for the construction components of this proposal.	Possible, as part of an integrated strategy
Alliance	Not appropriate for a project of this size.	No
Public private partnership (PPP)	Not appropriate for a project of this size.	No

The construction of a new 15 bed medium secure unit somewhere on the Mason Clinic campus is expected to be a standard process, and of a relatively small size and low complexity. Therefore a traditional procurement model is most likely to be suitable.

The master planning for the site is expected to provide a standard design for each of the units, where a new unit is required, with some minor configuration to the design as necessary (to meet the needs of the individual units). As such, the design component is already accounted for in the master planning. The units are expected to be completed sequentially, and as such, a DBB approach would typically be appropriate for construction of a new unit.

However, the current construction market is resource constrained due to the strong construction demand. New Zealand is experiencing significantly above average demand for construction including residential

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developments in Auckland, rebuilding following natural disasters and significant planned infrastructure investment. As a result, it is currently more difficult to source materials and secure subcontractors.¹¹

In the current marketplace, an ECI arrangement is considered appropriate as part of a wider strategy for the redevelopment. An ECI contractor would be involved in pre-construction and design, with a routine competitive bid/build phase following.

¹¹ PwC, Valuing the role of construction in the New Zealand economy, September 2016

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6. The Financial Case

The financial case sets out the analysis to show the proposed investment is affordable. The analysis shows the whole-of-life costs, to understand the total cost implications of the options and the impact of their timing. The different options have different capital investment and annual operational costs. We use a discounted cash flow analysis to compare the cost implications of the different options.

6.1 Expected cost of the short listed options

Table 21 summarises the base costs by option. In our analysis we have excluded the figure for contingencies. Instead, we treat any potential variations in the capital cost through sensitivity testing (described further in section 6.3).

Table 21 Cost summary

	Option 0 ¹²	Option 1	Option 2	Option 3
Construction capital investment required (without contingencies)	\$13.0m	\$16.0m	\$16.0m	\$17.1m
Short term remediation cost (without contingencies)	N/A	N/A	N/A	\$7.8m
Total capital investment (without contingencies)	\$13.0m	\$16.0m	\$16.0m	\$24.9m
Total capital investment (including contingencies at 10%)	\$14.3m	\$17.5m	\$17.5m	\$27.4m
Annual operating costs	\$4.9m	\$5.4m	\$5.4m	\$5.4m
Building maintenance costs (over 40 years)	\$4.8m	\$3.7m	\$3.7m	\$3.7m
Present value of costs (over 40 years) (Whole-of-life costs)	\$83m	\$92.9m	\$92.8m	\$76.0m

Source: RLB and Consult QS

The cost estimates are based on information provided by quantity surveyors and construction experts Rider Levett Bucknall (RLB) and Consult QS. The basis for the capital cost of the options are:

- Option 0 – remediation option plus an extension to Tanekaha of five beds
- Option 1 – construction of a new unit (as per Option 2) plus demolition costs¹³
- Option 2 – construction of a new unit

¹² Note that this table presents Option 0 as the cost of remediation plus expansion of five beds, to ensure consistency in the dollar values provided and enable a like-for-like comparison of the options.

¹³ The demolition costs have been derived using early information from QS Consult and added to the updated build costs from RLB.

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- Option 3 – construction of a new unit (as per Option 2) plus pro-rated infrastructure costs plus the remediation costs (excluding extension)

Option 3 includes a value for short term remediation costs. These have been included because it is expected that the time taken before Option 3 becomes operational will exceed the period when Tanekaha is habitable. Waitemata DHB expects that the process to identify a site, obtain the relevant building and resource consent, and then the construction process could take several years and Waitemata DHB expects that Tanekaha will need remedial work in the short term in order for it to be operational.

The table above shows the operational expenditure expected to be required to operate the building, under each of the options. Options 1-3 have higher operating costs than Option 0 because a medium security unit typically costs more to run than a minimum security unit. In particular, the Registered Nurse staff requirements are greater for medium security patients, along with marginal changes in other expenditure categories.

However, the proposed investment (regardless of option chosen) is expected to be cost neutral in terms of operating expenditure. Staff salaries, which make up majority of the overall operating costs, are not expected to change as a result of implementing any one of the options. It is expected that the staff will be re-allocated from existing units at the Mason Clinic. The patients who will reside in the proposed new unit already have staff allocated to them and their wages are already funded. The change in other operational expenditure e.g. electricity is not expected to be material.

The building maintenance costs for each of the options is expected to be funded using the existing maintenance costs for Tanekaha. The building maintenance costs are expected to be lower than the existing maintenance costs for Tanekaha, so they represent cost savings. As such, these are not included in the present value of costs.

6.2 Whole of life costs

6.2.1 Assumptions

Our key assumptions for the discounted cash flow analysis are outlined in the table below. These assumptions are used for the analysis of all options.

Table 22 Key assumptions for the financial analysis

Assumption	Value
Starting year for the analysis (year to June)	2017
Evaluation period	40 years
Inflation assumption	N/A ¹⁴
Discount rate (real)	6% ¹⁵

¹⁴ We have completed the discounted cash flow analysis with real (non-inflated) figures and a real discount rate.

¹⁵ We have used a real discount rate of 6%, in line with Treasury's current discount rate for infrastructure and special purpose (single use buildings) including hospitals. Refer to <http://www.treasury.govt.nz/publications/guidance/planning/costbenefitanalysis/currentdiscountrates>.

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We have made additional timing assumptions for the construction work involved in the different options. The additional timing assumptions are outlined in the table below. Option 3 is expected to take significantly longer to become operational, due to delays in identifying a site and obtaining the appropriate consents.

Assumption	Option 0	Option 1	Option 2	Option 3
Construction duration	13 months	13 months	13 months	13 months
Construction begins	August 2017	August 2017	August 2017	Remedial works begin in August 2017, new construction begins in August 2022 (five year delay)
Construction ends	September 2018	September 2018	September 2018	September 2023
Facility operational	September 2018	September 2018	September 2018	September 2023

As the construction costs are expected to fall over multiple financial years for Waitemata DHB, we have assumed that the costs fall equally per month over the expected construction period. This assumption may not be realised in practice when construction begins, however for consistency we have assumed this cost profile across all the options.

6.2.2 Results

The analysis of the cost analysis over a 40 year period are shown in Table 23 below. This includes both operational and maintenance costs, but as explained above we are not seeking additional funding for those items.

Table 23 Cost analysis over a 40 year period

Costs	Option 0	Option 1	Option 2	Option 3
Total cost (undiscounted)	\$209.5m	\$231.1m	\$231.0m	\$212.7m
Total cost (present value)	\$83.3m	\$92.9m	\$92.8m	\$76.0m

Option 0 has the lowest cost, while the cost of Option 1 and Option 2 require slightly more expenditure. Waitemata DHB expects that the clinical benefits of a new building to more than exceed the additional investment required. Option 1 and Option 2 are materially similar in terms of the expected cost.

Option 3 is the most expensive option, due to the remedial work which is required in addition to the new building and it excludes the cost of the land for the new site.

Options 1, 2 and 3 have the same building maintenance costs but Option 0 requires significantly more maintenance costs.

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6.3 Sensitivity testing

The project group, upon the advice of construction experts, considered that there are additional risks for the refurbishment option, above routine risks for new buildings. The risks are likely to result in additional costs to be incurred which are not factored into the cost estimates and modelling above.

The additional risks and costs for refurbishment projects can include:

- Collation of additional documentation as evidence that the design intent meets both code requirements and self-imposed standards. This can be difficult and time consuming to collect particularly if the evidence needs to be collected retrospectively, which may pose additional costs.
- Degradation of materials (e.g. timber) which is only known after construction begins and an associated cost (and timing issue) for testing and replacement of degraded materials.
- Quality of materials where this may no longer meet required standards, which take time and cost to identify and remedy (design and implement) the solution.
- Refurbishments have a higher rate of minor variations, which need consenting authority approval before construction continues, which imposes additional time and costs to the project.
- Structural deficiencies and passive fire projection deficiencies which are identified after a re-clad begins and require uncosted upgrades.

In addition to the construction related costs, it is becoming harder to occupy remediation projects during their re-clad.

As such, the project group considered that sensitivity testing for the construction costs for the refurbishment option should be higher than the new build options. The project group agreed to apply the sensitivity tests in Table 24 on the construction costs.

Table 24 Sensitivity testing on the construction cost estimates

Option number	Option 0	Option 1	Option 2	Option 3
High sensitivity test	Capex plus 30%	Capex plus 25%	Capex plus 25%	Capex plus 25%
Low sensitivity test	Capex minus 0%	Capex minus 25%	Capex minus 25%	Capex minus 25%

Table 25 Sensitivity testing cost analysis over a 40 year period

Option number	Option 0	Option 1	Option 2	Option 3
High sensitivity test	\$87.1m	\$96.8m	\$96.8m	\$81.1m
Low sensitivity test	\$83.3m	\$88.9m	\$88.9m	\$70.9m

The sensitivity testing on the costs reflects the higher risk of the remediation option. For this reason, the difference in the cost when the high-side risks are considered is reduced. There is some degree of possibility that the actual construction costs are lower than expected for the new build options, which is not expected in the remediate option. In this situation, the cost for Options 1 and 2 are slightly lower than Option 0.

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6.4 Outcome

Waitemata DHB considers that the additional clinical benefits for patients, in terms of implementing the recommended model of care, merits the additional investment in a new building, compared to the remediation option. Options 1 and 2 have the lowest cost out of the three new build options, with Option 2 slightly less than Option 1 (which includes the demolition costs).

The preferred option, Option 2, is expected to involve a capital investment of \$17.5m, with a present value of \$15.8m. The preferred option is expected to be cost-neutral in terms of its operational expenditure. This is the case with all the options, as staff are expected to be re-allocated to the new unit from an existing Mason Clinic unit. Building maintenance costs are expected to be funded from the existing Tanekaha maintenance costs. There is a cost-saving expected due to the smaller building maintenance costs for a new building, compared to the current Tanekaha unit.

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7. The Management Case

7.1 Implementation plan

Waitemata DHB has a successful track record in delivering health facility projects and would use established processes and procedures to guide the project team. This would ensure appropriate oversight of key decisions, including approval to proceed. These procedures include:

1. Change Control Procedures
2. Document Control
3. Monthly Reporting Processes
4. Issues Resolution
5. Construction Management Plan
6. Information & Communications Management
7. Quality Management Plan
8. Cost Management
9. Time Scheduling

A draft project execution plan has been developed to support the above processes and will be further developed and implemented in the next phase.

The project sponsor will determine the tolerances for project manager and implementation team. This would enable the project sufficient leeway to make local decisions without referring upwards for minor variances. If the agreed project tolerances are agreed, or are forecast to be exceeded, an exception report would be produced. Variances would be escalated to the Project Sponsor, and further to the Chief Executive if required, to ensure that control was maintained over the project as it progresses.

The build elements of the project will be managed by an experienced facilities manager. The overall project and change management would be managed by a dedicated project manager and will follow the Prince2 methodology.

Project risks will be managed in accordance with the processes set out in section 3.5, to help deliver this project on time and budget.

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7.2 Implementation timeline

The key project milestones and indicative dates are shown in Table 26.

Table 26 Key Project Milestones and Indicative Dates

Key Milestones	End Date
Business Case approval	March 2017
Design	July 2017
Tender	August 2017
Building consent	August 2017
Construction period	August 2017 to September 2018
Commissioning	September 2018
Facility operational	September 2018

The facility would be operational from August 2018, to accommodate a transfer of patients from Tanekaha.

7.3 Stakeholder engagement

The key internal and external stakeholders have been identified and are summarised in Figure 1. Approaches to communications and engagement throughout the development of this business case, and planned for the implementation phase, have been determined based on the degree of impact the project would have on each stakeholder/stakeholder group.

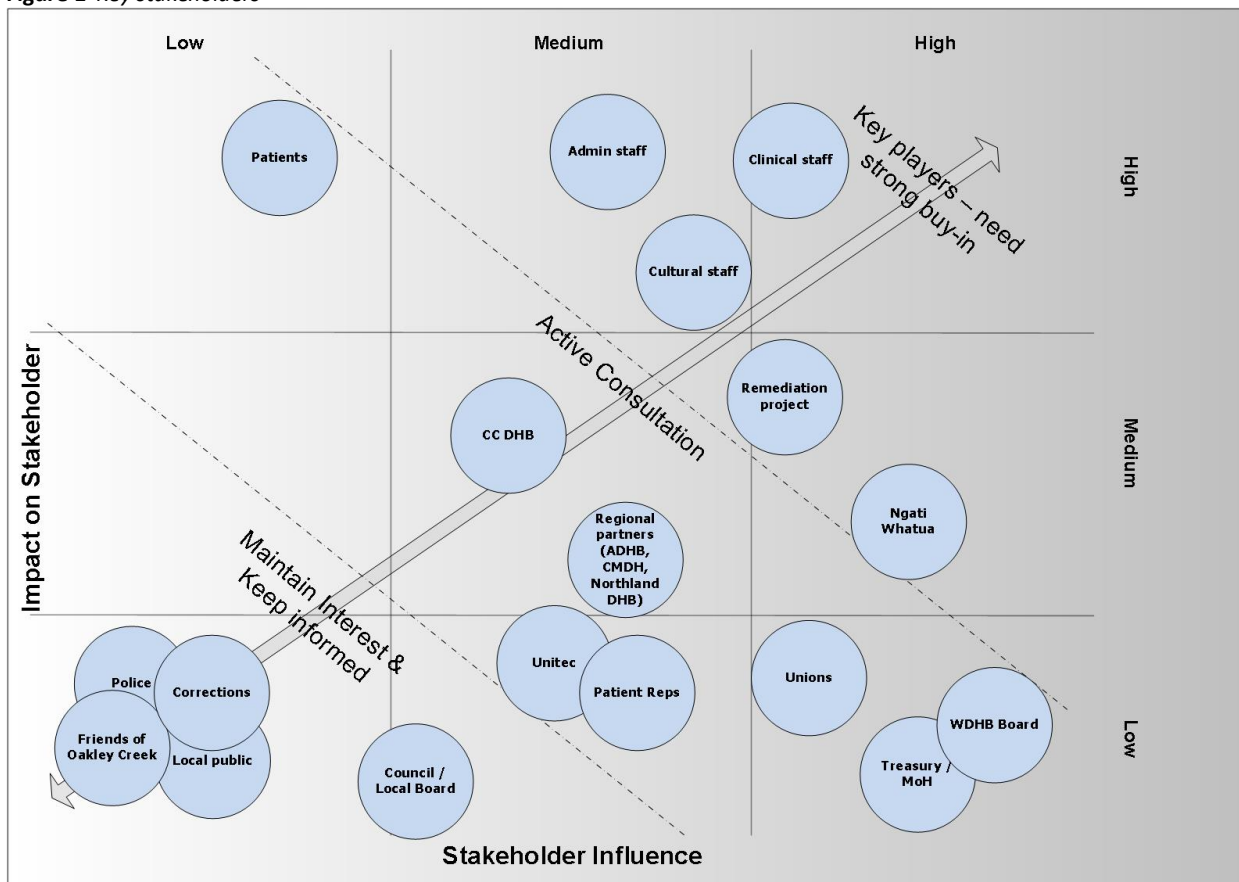
Stakeholder engagement has been a key component of the project to date including the broader campus redevelopment. Engagement has varied between stakeholder groups to meet the needs of that specific group.

Users have participated through focus groups on design and have been kept updated through the Mason Magazine. Cultural staff have been engaged in ensuring that the requirements meet cultural needs through engagement in design and planning meetings. Administrative staff have been kept informed through meetings and newsletters, clinical staff have been consulted on the design process and staff facility requirements. There have been meetings with the Unions, who receive monthly updates and newsletters. Unitec has been engaged, primarily regarding the sale or lease of land. Regional partners (the other three Northern Region DHBs) have been engaged through regional services planning. The Waitemata DHB Board, Treasury and MoH have received updates and briefings as the planning has progressed.

Communication and engagement will be a critical element of the project planning and execution. The communications plan will be refined during the detailed planning and implementation phase. For the key players there will be a continued focus on forums and meetings, supported by written materials (newsletters etc.). For the Active Consultation Group, it is intended that some engagement would be through meetings, but with a stronger emphasis on other communication methods, e.g. newsletters. Limited resource would mean that communication with the less impacted/influential stakeholders would be primarily through written means, e.g. newsletters and updates. The detailed communications plan for this project is available on request from the Project team.

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Figure 1 Key stakeholders



7.4 Change management

Limited change management would be required for the proposed investment in additional capacity. The most impacted stakeholders (staff and patients) would continue to provide, and receive, fundamentally the same service and care as under current arrangements, but in a different setting.

The wider remedial works project involves significant change management requirements. Change management planning will be undertaken, and will be utilised where required when the projects overlap. All relevant stakeholders (e.g. patients from Tanekaha and Rata units and their representatives, administrative and clinical staff) will be informed of the proposed migration to the new units. Initial discussions have occurred with affected staff on the indicative timeline and impact of the proposed moves.

7.5 Project Structure, Monitoring and Reporting

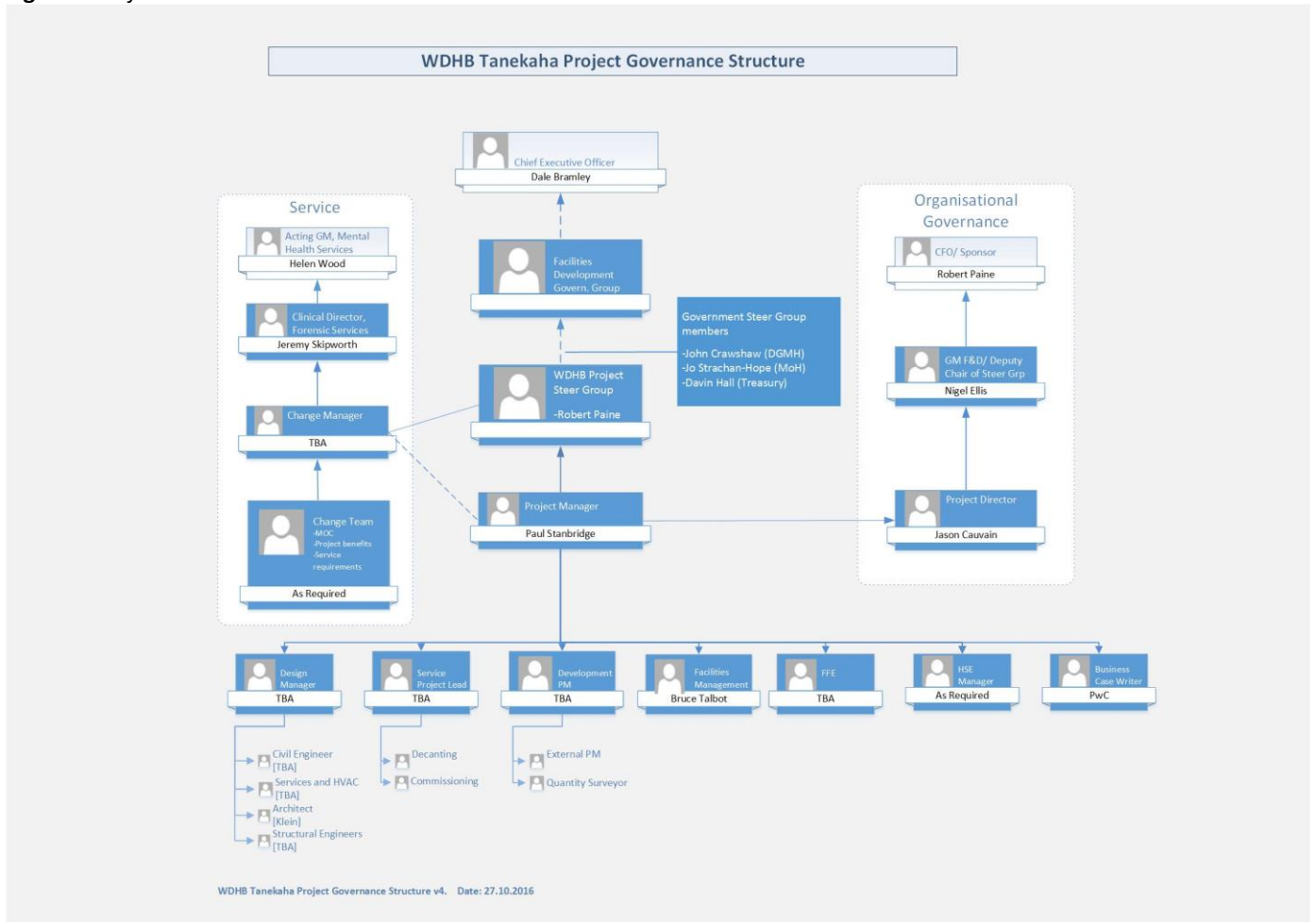
7.5.1 Project Structure

The Mason Clinic Project governance structure follows similar approaches to other major redevelopment projects undertaken by Waitemata DHB. This includes a project steering group that is already in place and comprises Forensic Services clinical staff, management staff, finance, facilities and a Waitemata DHB Executive Leadership member, the Chief Financial Officer (CFO) and Mental Health General Manager as the sponsor of the project. The proposed project structure showing the reporting arrangements is depicted in

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Figure 2. It is expected that the structure will be materially the same as those used in the past and is similar to the structure employed for the construction and operation of the new unit which is under construction.

Figure 2 Project Governance Chart



The Project Group governance structure is:

- Chief Executive Officer – Dave Bramley
- (Acting) General Manager, Mental Health Services – Helen Wood
- Clinical Director, Forensic Services – Jeremy Skipworth
- Change Manager – TBC
- Change team – TBC/As required
- Facilities Development Govern, Group – TBC
- WDHB Project Steer Group – Robert Paine
- Government Steer Group members – John Crawshaw, Jo Strachan-Hope, Davin Hall
- Project Manager – Paul Stanbridge
- Chief Financial Officer – Robert Paine
- GM F&D/ Deputy Chair of Steer Group – Nigel Ellis
- Project Director – Jason Cauvain

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7.5.2 Monitoring

The project will be subject to standard Waitemata DHB internal monitoring and review. This project is materially similar to the business case to expand the capacity of regional forensic psychiatry services which was assessed as “Medium” on the NZ Treasury Risk Profile Assessment, and hence there is no requirement for Major Project Assurance or Gateway review.

The identification, measurement and tracking of benefits would be undertaken to ensure that the expected outcomes are realised. The Project Sponsor will have overall responsibility for the realisation of benefits. Monitoring and delivery of benefits would be the responsibility of the Service Manager.

A detailed benefits register will be created and maintained by the project manager for the duration of the project, with post-project responsibility reverting to the Service Manager.

7.5.3 Reporting

A monthly update report will be provided by the Project Sponsor to the Chief Executive on project progress, i.e. if the project is on time, on budget and able to achieve the objectives of the business case. Progress reporting would also be made to the National Health Board, at agreed key milestone points.

7.6 Post Implementation Evaluation

Project Evaluation: This would take place within one month of project completion. It would confirm the extent to which deliverables have been completed and would reconcile the project budget and timelines to plan. This review would also consider lessons learned and would identify the extent to which the expected benefits have been realised at that point.

Post Project Review: This would take place within 12 months of project start. The review would assess the benefits realised compared to the business case, identify new benefits realised but not claimed in the business case, and include planning for ongoing improvements in performance. This review would provide assurance to the DHB that the project has delivered the anticipated benefits, or is on track to do so.

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8. Conclusion/ recommendation

8.1.1 Conclusion

The Tanekaha unit is failing as it suffers from weather tightness and “leaky building” issues, posing severe risks to the health of patients and staff. It is expected that without remedial works, Tanekaha will have to be closed in the future, which poses a risk to providing services to current patients and a risk of a break in the continuity of providing services at the Mason Clinic in the future. A growing prison muster means that the outcome of a break in the continuity of regional forensic psychiatry services is expected to be more pronounced in the future. The risk is deemed unacceptable.

The proposed investment is to construct a new 15 bed medium secure unit on the Mason Clinic campus (but not on the Tanekaha site). It is considered that this would provide the immediate solution to the failing Tanekaha unit, meet the recommended model of care, provide sufficient flexibility to be consistent with the long term master planning for the Mason Clinic campus, and provide for continuity of services.

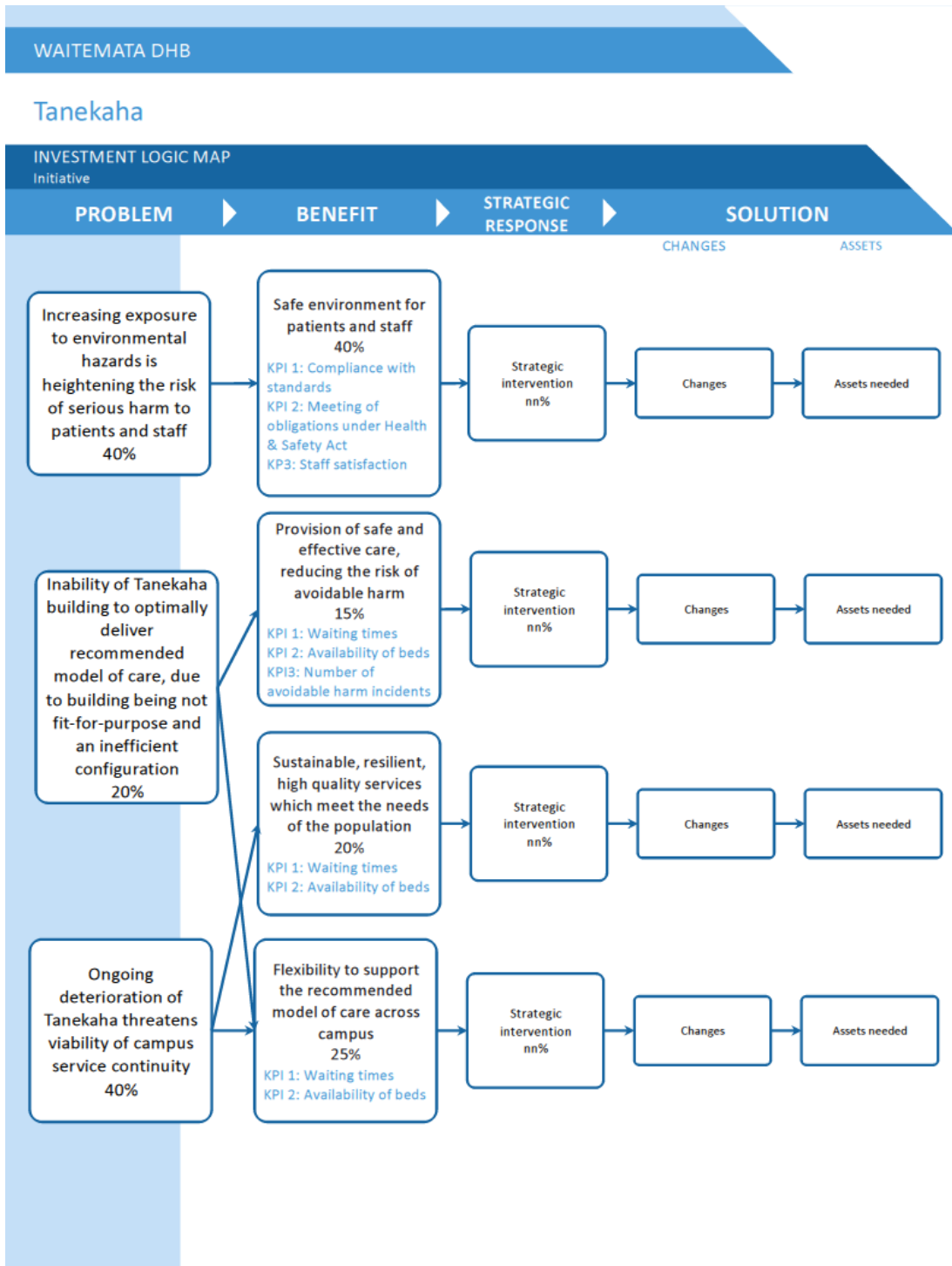
8.1.2 Recommendation

It is recommended that MoH’s Capital Investment Committee approves total capital costs of \$17.5m to construct a new 15 bed medium secure unit.

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9. Appendices

Appendix 1 - Investment logic map

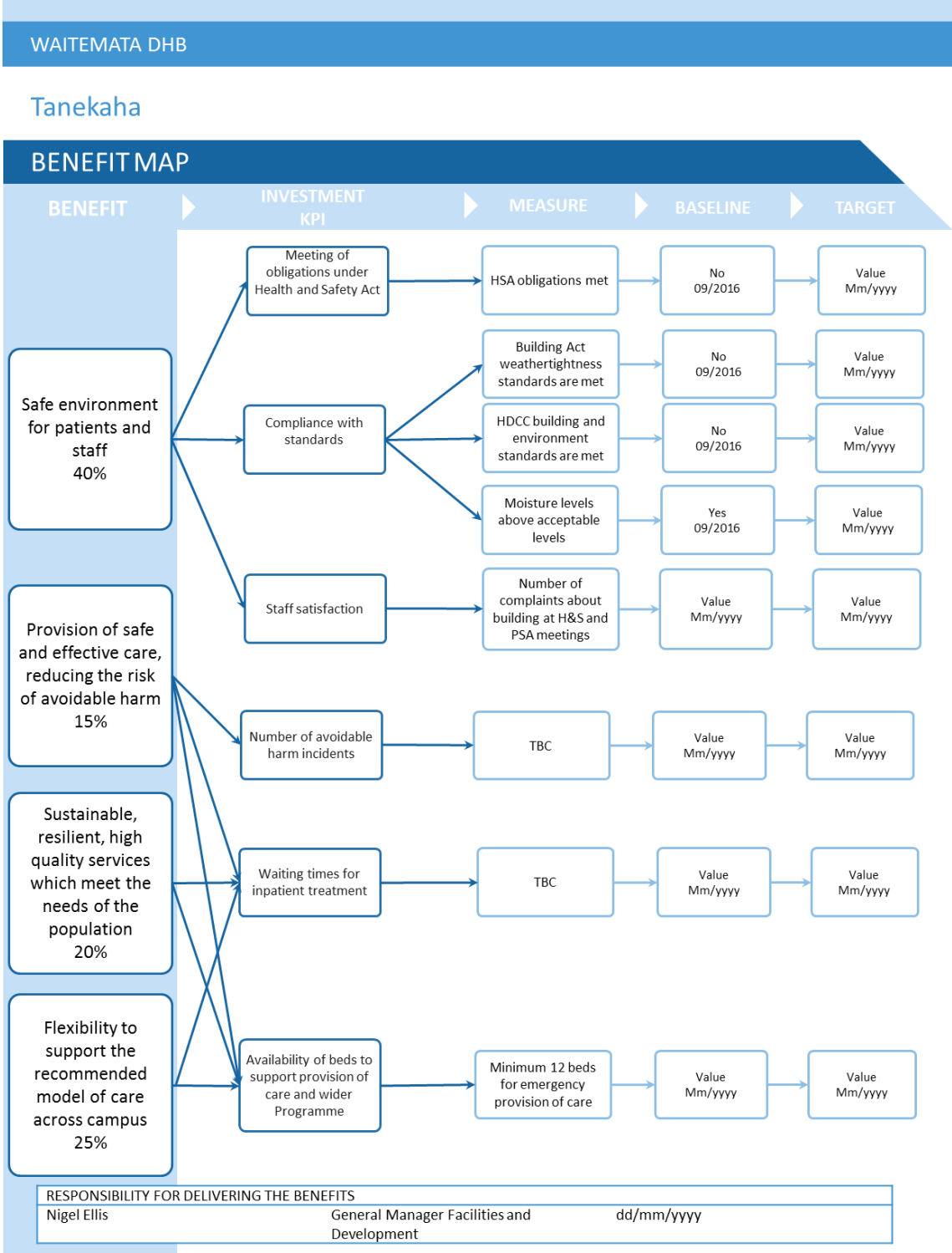


Investor: Nigel Ellis
Facilitator: Sylvia Meakin
Accredited Facilitator: Yes

Version no: 1.2
Initial Workshop: 13/09/2016
Last modified by: Mark Robinson 11/11/2016
Template version: 5.0

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Appendix 2 - Benefit Map



Business Problem Owner: Nigel Ellis
Facilitator: Sylvia Meakin
Accredited Facilitator: Yes

Version no: 1.2
Initial Workshop: 13/09/2016
Last modified by: Mark Robinson 11/11/2016
Template version: 5.0

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Appendix 4 - Updated proposed concept plan and schedule of accommodation

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Appendix 5 - Procurement models

Table 27 Characteristics of different procurement models and application to the new unit option

Model description	Waitemata DHB' risks	Contractor's risks	Payment mechanism	Use
<p>Design then construct/ design bid build (DBB) Waitemata DHB individually contract with separate entities for the design and construction phases of the project for the segments they are responsible for.</p>	<ul style="list-style-type: none"> Design or scope does not meet brief (though there is risk to Waitemata DHB that this is disputed between design and construction contractors) Site conditions Whole-of-life asset ownership risks Operational risks Disputes between design and general contractor over responsibility for issues cause delays and/or mean some contractor risk is pushed back to Waitemata DHB Separate design and construction contracts may lead to a design that is not buildable or that is not cost effective from a construction perspective. Lack of clarity over roles and responsibilities between Waitemata DHB and the contractor Infrastructure and resource 	<ul style="list-style-type: none"> Construction timetable breaches Cost of works (except for agreed variations) Construction trade performance Materials and workmanship including weather tightness Resource and subcontractor availability 	<ul style="list-style-type: none"> Fixed price (though subject to disputes, claims and variations) Progress payments based on milestones or cost of work completed Whole-of-life, maintenance and lifecycle type costs are retained by Waitemata DHB (though may be separately contracted out). 	<p>Best suited to projects where:</p> <ul style="list-style-type: none"> Waitemata DHB specifications can be clearly articulated before tender Specifications are unlikely to change and where Waitemata DHB is best placed to manage non-construction project risks Design is relatively uncomplicated, where the key procurement objective is ensuring a strongly competitive construction tender One design is repeated over Relationship with design team may be more interactive, which can reduce specification risks; however, it can also be harder to manage scope Operational risks best managed separately No upfront funding

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Model description	Waitemata DHB' risks	Contractor's risks	Payment mechanism	Use
	consent risks			constraints <ul style="list-style-type: none"> Low scope for innovation.
Design and construct (D&C) Waitemata DHB seeks tenders to provide a (typically) fixed price for design and construction.	<ul style="list-style-type: none"> Similar to DBB approach but risk of disputes between design and construction contractors is addressed May increase risk that scope does not meet needs as there is generally greater separation between the client and the design team Assumes Waitemata DHB can specify required outcomes clearly at the outset. 	<ul style="list-style-type: none"> Constructed design does not meet brief Construction timetable breaches Cost of works (except for agreed variations) Construction related risks as per DBB. 	As per DBB.	Similar to DBB but tends to be a quicker process as there is one tender process and D&C can overlap. Relative to DBB, it is better suited to more complex designs where there is a need for a closer relationship between the design and construction teams. More difficult than DBB because Waitemata DHB will give up some design control
Design, construct and maintain (DCM) Contractor retains responsibility for maintenance, but typically these models do not extend beyond the first major lifecycle phase.	Similar to the DBB approach: <ul style="list-style-type: none"> Scope definition Scope changes Site conditions Cultural and heritage risks Operational risks Residual ownership and asset performance risks beyond the term and scope of the maintenance contract. Also, potential for 	As per the D&C model, and also maintenance risk for the term and scope of the maintenance contract. Effective risk transfer can be limited by the lack of private finance at risk.	<ul style="list-style-type: none"> As per D&C Maintenance costs are paid periodically by Waitemata DHB. Incentive arrangements and competitive tensions during the original bid phase can drive the DCM contractor to provide some reduced maintenance costs, although this will depend on the relative value of the maintenance works and the D&C component. 	DCM contractor retains responsibility for some lifecycle maintenance, so these models suit projects where there is: <ul style="list-style-type: none"> Opportunity to introduce D&C innovation on a whole-of-life basis Need to create longer term alignment of interests between the contractor and the owner Desire for a different risk allocation.

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Model description	Waitemata DHB' risks	Contractor's risks	Payment mechanism	Use
	inconsistency with existing maintenance contracts and processes for the campus.			
<p>Early Contractor Involvement (ECI) Typically, the preferred ECI contractor is selected under open competition for a whole of project contract (i.e. including design development, design and construction). Typically, agreements are staged, and either a D&C or bid/build contract is entered into with the ECI contractor following the detailed definition phase. A further contract could then be entered into to provide maintenance and (potentially) operations services.</p>	<ul style="list-style-type: none"> All risks retained exclusively by Waitemata DHB during development and definition phase If the ECI converts to a subsequent contract, the risk allocation profile is as per the new contract, including whole-of-life ownership and operational risks However, these risks would likely be lower as major design risks should have been dealt with during the development and definition phase. 	<p>D&C or bid/build types of risks accepted by the ECI contractor following agreement.</p>	<ul style="list-style-type: none"> During the design development phase, the ECI contractor is reimbursed at agreed rates on a time basis. Based on preliminary design and draft construction contract, the contractor prepares a fixed price to undertake construction. Price is prepared on an open book basis utilising standard rates and margins originally bid by the contractor. This price may then be market tested. Waitemata DHB would engage an external auditor to verify the price prepared prior to fixing in the D&C or bid/build contract. Payments are made similar to the subsequent arrangement. 	<ul style="list-style-type: none"> The ECI model has been used when cost, risks and scope cannot be sufficiently defined upfront and where there are opportunities to access contractor innovation in design and development. ECI should reduce opportunity for successful claims and variations compared with D&C or bid/build only if the risk allocation of the underlying contract is different. This reflects the ECI's involvement during development, better understanding of Waitemata DHB' requirements and project risks and more clearly defined allocation of responsibilities and risks.

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Model description	Waitemata DHB' risks	Contractor's risks	Payment mechanism	Use
<p>Alliance</p> <p>An Alliance relationship is formed between key project participants, which include Waitemata DHB and non-owner participants (e.g. designer, constructor, other key stakeholders, etc). The relationship must be collaborative for the Alliance to be effective. Options are available to develop the Target Outturn Cost (TOC) in a competitive environment. However, most alliances have tended to use a single party to develop the TOC. This relies on the owner implementing approaches that create appropriate cost, quality and scope tensions, and the right level of expertise to critically validate the TOC, including risk quantification. A further contract would likely then be entered into to provide maintenance and (potentially) operations services.</p> <p>A key feature of Alliances is the gain share pain share incentive mechanism.</p>	<ul style="list-style-type: none"> Alliances are predicated on 'no blame' and collective assumption of all project risk basis (ie parties share 'pain'). Waitemata DHB share the risks during the D&C phase with the Alliance participants. The extent of the Alliance participants' financial exposure to adverse risk outcomes depends on specified sharing arrangements but is generally limited to their margin (corporate overhead and profit). Waitemata DHB remain fully exposed to the underlying project procurement costs, including the resultant costs of the occurrence of all project risks. All asset ownership and whole of life risks are retained by Waitemata DHB. Operational risks are retained by Waitemata DHB. 		<ul style="list-style-type: none"> Non-owner parties are typically guaranteed reimbursement of their direct project costs and payment of corporate overheads in an open-book arrangement. Targets for cost, schedule and other key result areas are developed jointly during pre-construction phase. If actual delivery is better than agreed targets all participants share reward ('gain-share'). If delivery does not meet agreed targets, a pre-agreed 'pain-share' formula applies (where the margins of non-owner participants will be at risk). Construction and other costs are paid over the course of the construction period on the basis of reimbursement of cost incurred (monthly). 	<ul style="list-style-type: none"> Typically used in high risk projects where it is difficult to effectively define and transfer risk and there is uncertainty around scope definition, design complexity, delivery complexity, and complex interfaces which will influence design and construction outcomes. The model provides early collaboration of the designer and contractor in the project, providing opportunities to access construction expertise in the development of the design, definition and construction programming.

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Model description	Waitemata DHB' risks	Contractor's risks	Payment mechanism	Use
<p>Public Private Partnership (PPP)</p> <p>Generally, a private sector contractor (or contractor consortium) is responsible for the design, construction, operation, maintenance and finance over an extended period (typically 25-30 years). This is a typical long-term, whole-of-life approach to infrastructure delivery. Risk allocation is determined up front for the period of the contract, including maintaining the infrastructure and providing the services to a pre agreed condition for the duration of the concession. Risk transfer, bundling of whole-of-life costs and incentives from having private finance at risk can drive increased innovation.</p>	<p>Some risks are common to the DBB/D&C models including:</p> <ul style="list-style-type: none"> • site conditions (possibly) • cultural and heritage. <p>Additional risks include:</p> <ul style="list-style-type: none"> • transfer back risk • market changes that cannot be adapted to due to the long term PPP contract. <p>Waitemata DHB will only bear the risk that is specifically allocated to the individual organisation. This means that all unspecified risks are borne by the private sector consortium.</p>	<ul style="list-style-type: none"> • Majority of D&C and maintenance risks on a whole-of-life basis are transferred to a private sector consortium, which has full ownership risk over the assets. (No service, no payment; substandard service, reduced payment). • Private sector consortium has full exposure (of all its capital invested) to consequences of design, construction and maintenance judgments and trade-offs over the life of the project. 	<ul style="list-style-type: none"> • Waitemata DHB make service payments once the project delivers the services at the required standard (ie post commissioning). Consortium pays D&C sub-contractors during construction through private financing, which is subsequently repaid to consortium from Waitemata DHB' service payments over the term of the contract. • The payment mechanism links with a key performance indicator (KPI) and service specifications regime and provides for reduced payments for poor performance or lack of availability during the concession. • In theory, the PPP model could involve the consortium assuming risk (e.g. having payments linked to the number of patients). However, there is currently limited appetite from private sector financiers to take 'risk'. 	<ul style="list-style-type: none"> • Where there is a clear measurable service output against which performance can be measured. • Where there are opportunities for significant effective risk transfer to the private sector (including D&C and whole-of-life risks). • Where there is opportunity for private sector innovation in any or all aspects of the project (D&C, finance, O&M) to add value. • Where benefits can be realised through a whole-of-life approach to design and costing, i.e. there is a strong connection between the specific design, construction materials and the level and type of maintenance costs.
<p>Privatisation</p> <p>Full transfer of rights to the private sector through sale.</p>	<p>Control over the infrastructure or land transferred to the private sector.</p> <p>Ability to ensure quality of service</p>	<p>All risks rest with private party.</p>	<p>Negotiated through the sale process.</p>	<ul style="list-style-type: none"> • May be applicable to certain small components of the project only (e.g. redevelopment of land

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Model description	Waitemata DHB' risks	Contractor's risks	Payment mechanism	Use
	over the long-term could be challenging.			<p>surrounding new stations, if this is currently owned).</p> <ul style="list-style-type: none"> Funds from any sale could be used to offset the costs of any of the other procurement methods.
<p>Public provision This would involve direct provision from Waitemata DHB.</p>	All risks reside with the individual Waitemata DHB for the segments they are responsible for.	N/A	N/A, as there is no contractual party	Not suitable as a full procurement option, but may be used in conjunction with another method.

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Appendix 6 -Updated plans for Options 1 and 2

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Appendix 7 - Master plan design report



DHB Chief Executive Office
Waitemata DHB
Level 2, 15 Shea Terrace, Takapuna, Auckland
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06 July 2018

Dr Ashley Bloomfield
Director General of Health and Chief Executive
Ministry of Health

Email: ashley_bloomfield@moh.govt.nz

Dear Dr Bloomfield,

I write to bring a number of issues of concern to your attention.

Waitemata DHB hosts one of the National Intellectual Disability Secure Services at Mason Clinic in Auckland. This service is for hospital level care for people with intellectual disabilities who have come to the attention of criminal justice system or present with extraordinary high and complex needs. Pohutukawa Unit, at Mason Clinic provides 10 'care and rehabilitation' beds and 2 'assessment' beds accessible to the Forensic Coordination Services – Intellectual Disability (FCS-ID – formerly known as NIDCA). Although all beds are administered nationally by FCS-ID the WDHB beds are primarily servicing half the NZ population living essentially in the Midlands, Auckland and Northland regions.

The DHB has consistently highlighted concerns over inadequate and geographically unbalanced availability of hospital level secure beds for people with ID and sought to offer solutions since 2014.

The situation is now severe and we request an urgent response. Since 2008 Pohutukawa unit has not been expected to manage long term needs of women requiring this level of care due to the small size of the service and the predatory nature of the behaviours of concern of many of the male residents. Capital and Coast DHB provided specialist services to this small subgroup of women from across the county up until recently at which point, without consultation, the expectations changed. Pohutukawa unit has now had two women admitted in 2018. Both are having to share bedroom corridors with male care recipients raising significant concerns over the inappropriate mixing of genders and the negative consequences this is having on both the females and their male peers. Safety is being managed by the use of increased close observations which is draining resources and diverting resources from rehabilitation.

Services in Pohutukawa unit are at capacity and bed areas are blocked by the lack of long term provision for complex individuals on the autistic spectrum of disorders who are unable to mix safely with peers and for whom high intensity staff support is required.

FCS-ID has been requesting WDHB to utilise mental health beds for many individuals who have dual disabilities but require ID specific services to progress to rehabilitation and lower levels of security. This not only provides sub-optimal care for these individuals but also blocks access for people with mental health problems not able to access any other services and this is reflected in the growing waiting lists of people needing forensic beds in Mason Clinic who are currently inappropriately in prison. Whilst WDHB would like to continue to be flexible and accommodate these individuals, the lack of transparency and diversion of resources away from people who do not have ID is neither appropriate or sustainable.

WDHB has expressed a strong preference for care for local people to be delivered locally and advocates for people in the northern half of the country to enjoy, at least, equitable access to services offered elsewhere in the county. The DHB has already expressed its concerns to Jill Lane and Dr Crawshaw about the consultation processes undertaken to date and the need to greatly enhance the northern region's participation in planning and decision making around proposed individualised service units for high and complex and dual disability individuals currently underway in the Capital and Coast DHB region.

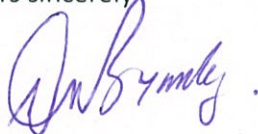
The MoH have very recently signalled an intention to fund four additional beds to the Northern regions but, with the additional changes in relation to gender mix, it appears likely these beds will now need to be used for all purposes including accommodating: youths on assessment, women throughout their care and rehabilitation, high and complex individuals on the autistic spectrum of disorders, people requiring very long stay containment rather than true rehabilitation and people in need of genuine step down provision to bridge the manifest gap between hospital and community secure services in keeping with the continuum already offered to individuals in all regions except our own. It is apparent that meeting these diverse needs in four additional beds is unlikely to be adequate.

WDHB is at a crucial point at present developing our master facilities plan for forensic services for the region to ensure facilities are fit for purpose, to meet projected needs over the next 25 years and beyond. This is a critical point at which realistic planning for the needs of people with ID must also be undertaken. We would like to see appropriate and joined up planning for the future level of need in the northern region, a key principle of which should be northern clients are cared for close to their homes.

As the Ministry of Health purchase this capacity, we seek your assistance to facilitate urgent short and longer term planning for this small but extraordinarily complex and under-resourced group. Waitemata DHB is very willing to plan for the necessary increase in beds, but we are concerned that the 4 beds in contemplation are not sufficient. We also need further clarity about long term facilities requirements linked to the DHB long term master plan.

We look forward to working with you and your executive on this matter. Dr Jeremy Skipworth, our Clinical Director of this service is our key contact person.

Yours sincerely



Dr Dale Bramley
Chief Executive Officer
Waitemata District Health Board

Cc: Dr Jeremy Skipworth, Clinical Director Regional Forensic Psychiatry Services
Cc: Professor Judy McGregor, Chair of Waitemata District Health Board

Mason Clinic Masterplanning

Clinical Team Presentaion

Job Number
3.1157

Issue Date
09 Nov 2018

Revision
A

Client
Waitemata District Health Board



Introduction

Agenda

- Existing Conditions
- Service Requirements and Masterplan Phasing Strategy
- Land Acquisition
- Further Background

Existing Conditions

Location



Existing Conditions

Existing Site



Building Index

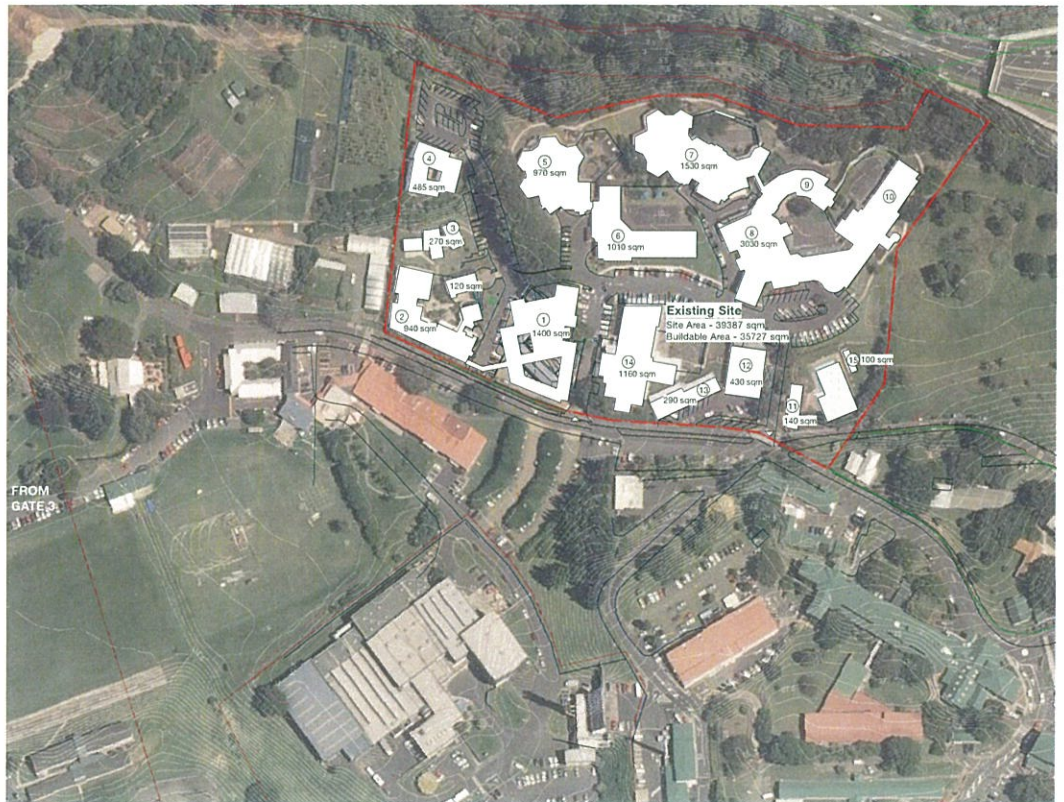
- 1 Te Aka - 15-bed Medium Unit
- 2 Tane Whakapiripi - 10-bed Minimum Unit
- 3 Te Miro - cultural building
- 4 Rimu - 8-bed & 1-overnight Open Unit
- 5 Tanekaha - 10-bed Minimum Unit
- 6 Kahikatea - 20-bed Minimum Unit
- 7 Rata - 15-bed Medium Unit
- 8 Mason Clinic - Medium Unit
- 9 Kauri Wing - 15-bed Medium
- 10 Totara Wing - 15-bed Medium
- 11 Pool Building
- 12 Garages / Workshop / Vocational Rehabilitation
- 13 Kowhai
- 14 Pohutukawa - 10-bed & 2-assessment Medium Unit
- 15 Puriri

Bed Numbers

Total bed no. existing 121

Carparking

Carparking no. existing 195 spaces on grade
 Existing total GFA 11239 sqm
 Existing spaces required 11239 / 50 = 225 spaces
 Carparking no. shortfall existing 30 spaces



Service Requirements & Masterplan Phasing Strategy

The site masterplan will be carried out over three separate tranches:

- **Tranche 1**

- Replacement of 60 beds to allow for the demolition of Kahikatea, Rata, Kauri and Totara, services relocation and ground remediation
- Tribunal suite and interim Front of House
- Two level carpark building and Facility/Support building
- Community Activity Centre and secure garden enclosure

- **Tranche 2**

- Two High & Complex units (30 beds)
- ID unit (12 beds)
- Youth facility (15 beds)
- Three level carpark building

- **Tranche 3**

- A pair of T2 and T3 units (30 beds)
- Open unit (9 beds)
- Front of House building and Community Activity building
- Additional support facilities

Masterplan Phasing Strategy

Current Condition

Total nr of beds 106
 Total nr of car parking spaces 196














Key

- T1
- T2
- T3
- Open
- ID
- H&C
- Activity
- Support
- Youth
- On Grade Car Park
- Multi Storey Car park
- Road
- Airlock



Masterplan Phasing Strategy












Tranche 1 - Stage 1

Total nr of beds	121
Total nr of car parking spaces	196
Key	
T1	
T2	
T3	
Open	
ID	
H&C	
Activity	
Support	
Youth	
On Grade Car Park	
Multi Storey Car park	
Road	
Airlock	



Masterplan Phasing Strategy

Tranche 1 - Stage 2













Total nr of beds	121
Total nr of car parking spaces	275
Key	
T1	
T2	
T3	
Open	
ID	
H&C	
Activity	
Support	
Youth	
On Grade Car Park	
Multi Storey Car park	
Road	
Airlock	



Masterplan Phasing Strategy

Tranche 1 - Stage 3

Total nr of beds 121
 Total nr of car parking spaces 383

- Key
- T1 
 - T2 
 - T3 
 - Open 
 - ID 
 - H&C 
 - Activity 
 - Support 
 - Youth 
 - On Grade Car Park 
 - Multi Storey Car park 
 - Road
 - Airlock 



Masterplan Phasing Strategy

Tranche 2 - Stage 1

Total nr of beds 178
 Total nr of car parking spaces 383

Key

- T1
- T2
- T3
- Open
- ID
- H&C
- Activity
- Support
- Youth
- On Grade Car Park
- Multi Storey Car park
- Road
- Airlock



Masterplan Phasing Strategy

Tranche 2 - Stage 2



764 | MASON CLINIC AUCKLAND
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Drawing Title: Staging Strategies
 No.: 353b
 Scale: 1:2,000
 Date: 28/09/2016

Masterplan Phasing Strategy

Tranche 3

Total nr of beds 217
 Total nr of car parking spaces 491

Key

- T1
- T2
- T3
- Open
- ID
- H&C
- Activity
- Support
- Youth
- On Grade Car Park
- Multi Storey Car park
- Road
- Airlock



Land Acquisition

Design Drivers



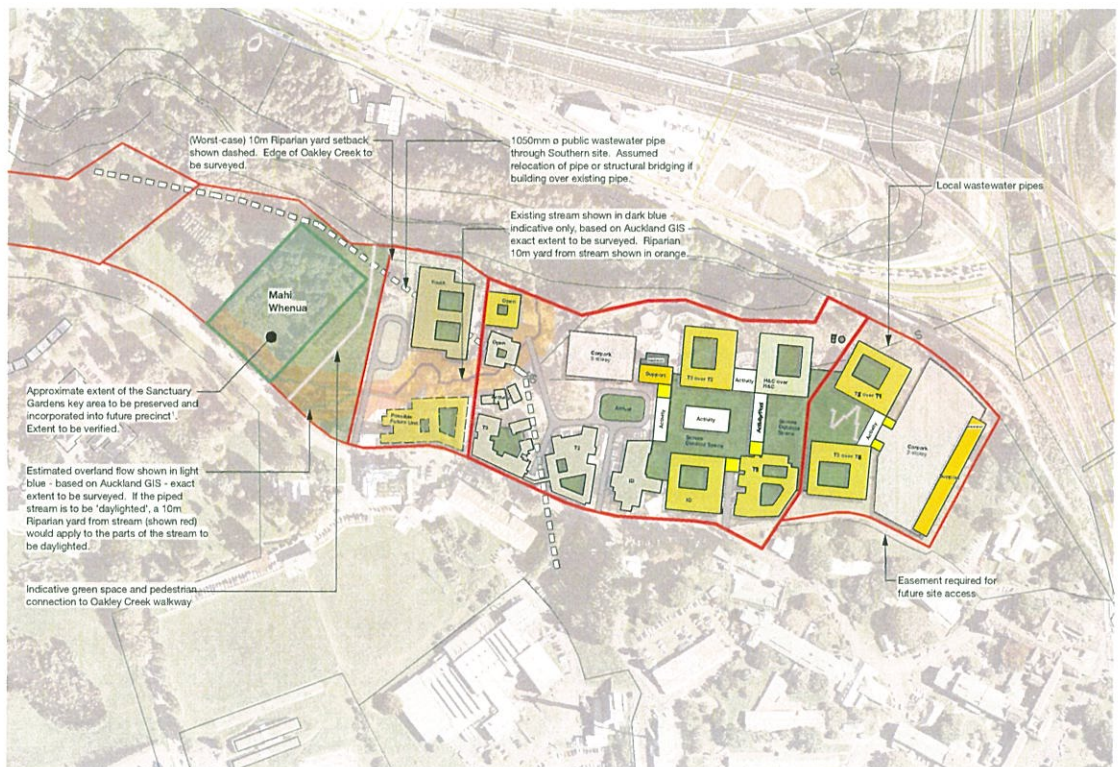
The following design drivers inform the expansion requirement for the Northern and Southern land parcels:

- **North**

- Replacement of 60 beds to clear the site for demolition, services relocation and ground remediation

- **South**

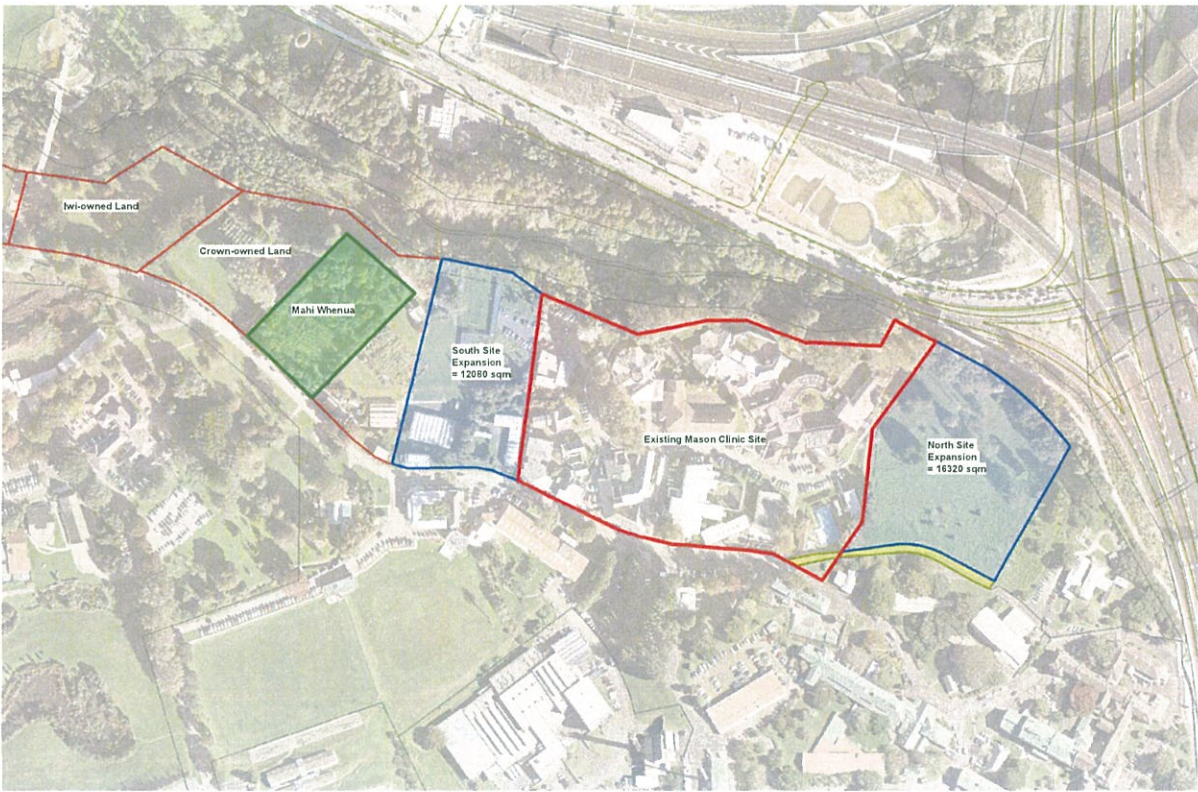
- Alignment with Wairaka precinct plan's urban design drivers
- To maintain public connection between the creek and the public road
- To recreate parkland between Mahi Whenua and Mason Clinic
- Sufficient site area to accommodate two units on the South site given some of the site constraints



Job No: 3.1157
Drawing No: SK-103
Revision: C

Land Acquisition

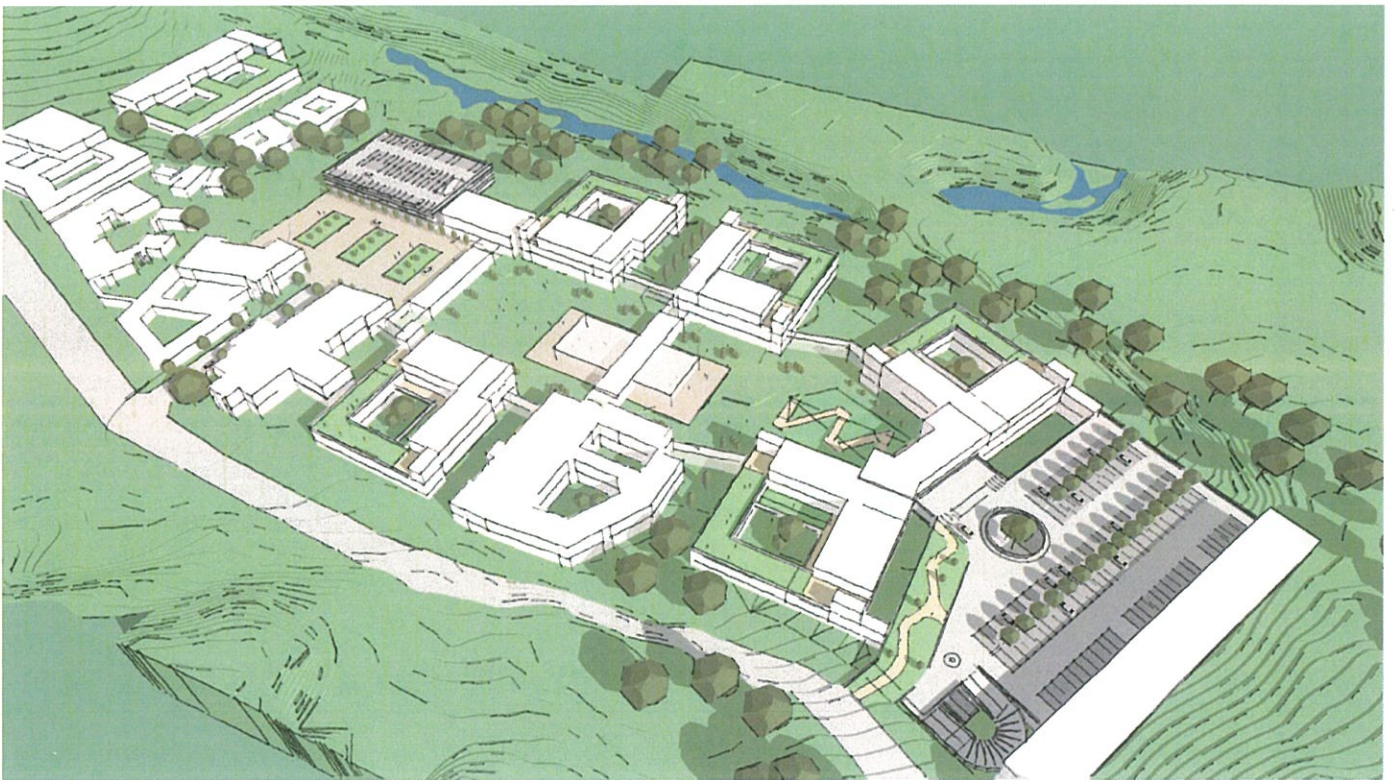
Proposed Land



Job No. Drawing No. Revision
3.1157 MP-050 A

Conceptual 3D View

Aerial North East

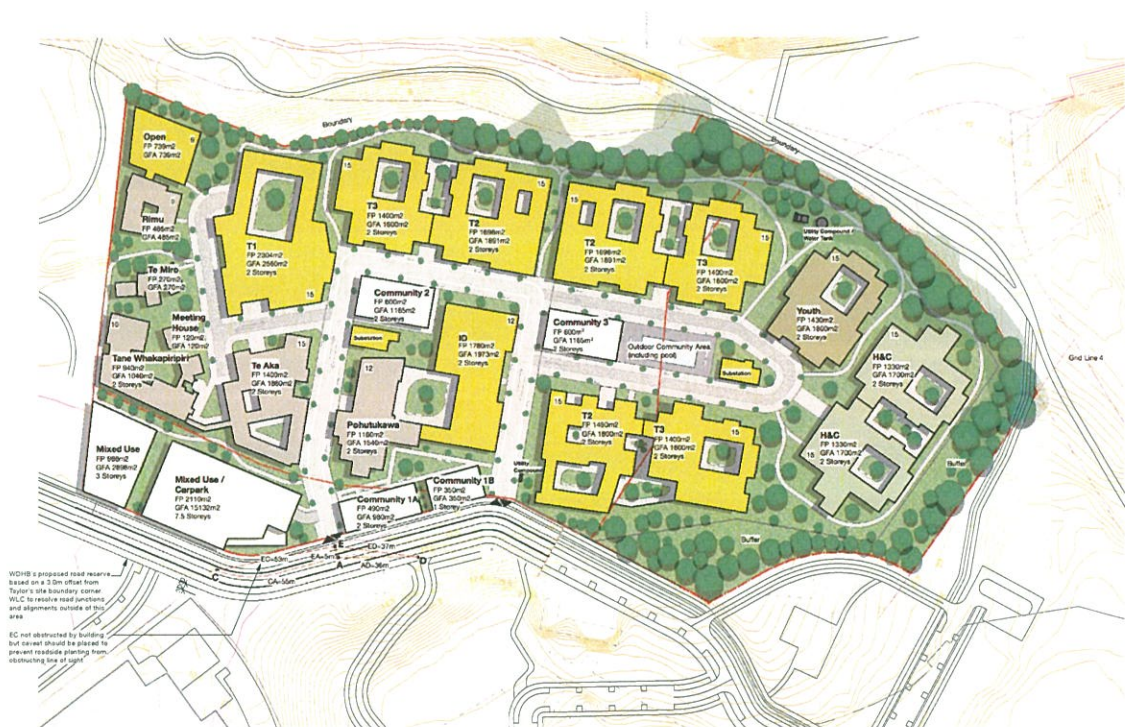


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Registered NSW Registered Architect: Tom Kevin Jones 1927

Drawing Title: 3D set - Aerial North-East
No.: 501
Scale: not to scale
Date: 23/10/2018

Further Background

Why not the east site?



Our ref 492764
Contact Philippa Hercus/David Scott
25 January 2019



Dr Dale Bramley
Chief Executive Officer
Waitemata District Health Board

By email: Dale.Bramley@waitematadhb.govt.nz

Dear Dr Bramley

Two systemic investigations into Intellectual Disability Issues

The purpose of this letter is to advise that I am currently undertaking two self-initiated investigations under the Ombudsmen Act 1975¹ into the administrative practices of the Ministry of Health (the Ministry) in providing services for people with an intellectual disability.

The Ministry is the only agency subject to my investigations. However, as part of the investigations, I will seek relevant information from key stakeholders pursuant to section 19(1) of the Ombudsmen Act 1975, which authorises an Ombudsman, subject to certain limitations, to require any person to produce information relating to any matter that is being investigated by the Ombudsman.

This will include Waitemata DHB, as the provider of intellectual disability (and mental health) secure services in the Auckland region.

I intend to make a public announcement about both investigations next month. In the meantime, I would appreciate you keeping the investigations confidential, and only sharing the content of this letter with key staff members. The findings of the investigations, and any recommendations I may make, will be set out in reports published on the Ombudsman website and tabled in Parliament.

First investigation – reporting of deaths of people with an intellectual disability

The first investigation, which I notified to the Ministry on 26 October 2018, concerns the recording and reporting of deaths of people with intellectual disability. In particular, people who are receiving full-time support funded by the Ministry in secure, supervised and community-level supported residential care. My investigation will consider what data the Ministry is collecting about the deaths of people in this group, the extent and quality of that data, and how it is analysed, used and reported.

For your information, I **enclose** a copy of the Terms of Reference for this investigation, which sets out the scope and process of my investigation. This Office intends to request relevant information from Waitemata DHB, after information obtained from the Ministry has been fully reviewed. We will be in touch again in the coming months about this investigation.

¹ See sections 13(1) and 13(3) of the Ombudsmen Act.

Second investigation – facilities and services for people with an intellectual disability

The second investigation, which I commenced on 22 January 2019, concerns facilities and services for people with an intellectual disability, particularly those who are subject to the High and Complex Framework (HCF).²

My investigation will cover the role of the Ministry in planning, resourcing and co-ordinating HCF facilities and services provided by the National and Regional Intellectual Disability Secure Services contracted through District Health Boards. The investigation will use anonymised case studies as part of considering whether capacity and capability issues in forensic intellectual disability services impact on selected individuals.

As an initial step, over the next few weeks, my staff intend to contact a number of individuals in order to elicit information relevant to the investigation, as well as their family/whānau/legal representatives. Two of the individuals concerned currently reside at Waitemata DHB's Mason Clinic. I am mindful that this engagement needs to occur in a sensitive manner that minimises any disruption or distress. As such, we will consult with the appropriate staff at Waitemata DHB about how to best manage this process. In the first instance, my staff will contact the Clinical Director of the Mason Clinic, Dr Jeremy Skipworth, by email.

I **enclose** a copy of the Terms of Reference which sets out in detail the scope and process of the second investigation. As the investigation progresses, we will let Waitemata DHB know what further information may be required.

Summary

If you or your staff have any questions, they are more than welcome to contact Philippa Hercus, Systemic Improvement Investigations Manager on (04) 460 9733, philippa.hercus@ombudsman.parliament.nz or David Scott, Senior Investigator on (04) 460 9712, david.scott@ombudsman.parliament.nz.

Thank you for your assistance with this matter.

Yours sincerely



Peter Boshier
Chief Ombudsman

Encl Terms of Reference: reporting of deaths for people with an intellectual disability
Terms of Reference: facilities and services for people with an intellectual disability

Cc: Dr Jeremy Skipworth, Clinical Director of Mason Clinic

² HCF refers to the framework of supports provided to care recipients subject to the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (IDCCR Act), including eligible civil clients.



Investigation terms of reference: Ministry of Health facilities and services for people with an intellectual disability

22 January 2019

Introduction

This document sets out the terms of reference for a self-initiated investigation by the Chief Ombudsman¹ into the role of the Ministry of Health (the Ministry) in providing facilities and services to people with an intellectual disability, particularly those who are subject to the High and Complex Framework (HCF).²

Purpose of the investigation

The purpose of this investigation is to examine the role of the Ministry in planning, resourcing and co-ordinating HCF facilities and services provided by the National and Regional Intellectual Disability Secure Services (NIDSS/RIDSS) that are contracted through District Health Boards (DHBs). The investigation will identify whether the Ministry has systems, policies and processes concerning the care and rehabilitation of people with intellectual disability under the HCF, which are consistent with good administrative practice.

The investigation will take into account relevant international conventions, including the United Nations Convention on the Rights of Persons with Disabilities and the United Nations Convention on the Rights of the Child. The investigation will identify areas of good practice and make suggestions for improvement if any areas of concern are identified.³

¹ See sections 13(1) and 13(3) of the Ombudsmen Act 1975 (OA).

² HCF refers to the framework of supports provided to care recipients subject to the Intellectual Disability (Compulsory Care and Rehabilitation) Act (IDCCR Act) 2003, including eligible civil clients who have high and complex needs that are beyond the scope of mainstream services.

³ Formal recommendations under the OA will only be made if the Chief Ombudsman forms an opinion that a decision, recommendation, act, or omission by the Ministry was unreasonable or contrary to law etc, under section 22 of the Act.

Scope of the investigation

The investigation will examine the role and accountabilities of the Ministry in delivering services to people with an intellectual disability under the HCF, including:

1. The systemic capacity of the NIDSS/RIDSS to admit and treat individuals referred by the Courts under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (IDCCR Act) who require a secure hospital-level bed.
2. The adequacy of facilities and environments for the secure care of people with intellectual disabilities, including:
 - a. longer-term clients with higher needs;
 - b. women clients; and
 - c. youth clients.
3. The adequacy of workforce planning by the Ministry to ensure the availability of trained staff to work in the HCF.

The investigation will focus on capacity and capability issues affecting NIDSS and RIDSS in the five relevant DHB locations. It will consider the manner in which the Ministry has worked collaboratively with the DHBs contracted to provide NIDSS/RIDSS to address service delivery issues.

Where appropriate, the investigation will also consider the extension of these issues to mainstream intellectual disability support services. The investigation will not include a comprehensive analysis of mainstream service delivery issues but will consider the interface between secure and community-level care.

The primary focus of the investigation will be on events that have taken place since January 2013.

The investigation will use a number of case studies of individuals currently living under the HCF, to highlight the issues under examination by the Chief Ombudsman.⁴

Investigation process

The Manager Systemic Improvement Investigations will work with a team of Senior Investigators and Advisors to assist the Chief Ombudsman to conduct the investigation. The investigation team will liaise with the Ministry's nominated contact officials during the investigation. Information will be gathered through the processes set out below.

⁴ The identity of case study participants will be confirmed after contact with each individual has occurred via their NIDSS/RIDSS provider.

Information gathering

General

The information for the investigation will be gathered through research, a review of relevant documentation held by the Ministry, meetings and/or interviews with key staff, and engagement with relevant third parties including individuals and their families/representatives who appear as case studies in the report.

Any requests for information are subject to the confidentiality and secrecy provisions in the Ombudsmen Act. Under section 18(2) of the Act, every investigation by an Ombudsman must be conducted in private. Under section 21(2) of the Act, an Ombudsman and staff must maintain secrecy and only:

... disclose such matters as in the Ombudsman's opinion ought to be disclosed for the purposes of an investigation or in order to establish grounds for the Ombudsman's conclusions and recommendations.

Under section 19 of the Act, an Ombudsman can require any person to provide information relating to any matter under investigation. This empowers the Ombudsman to gather evidence, from both the Ministry and third parties, including by way of interview.

Research

The research will include a review of publicly available information, including the legislative framework governing the provision of services to clients subject to the HCF, the Ministry's annual reports, strategic intentions documents, contracts and service specifications and any other material available on its website.

Review of Ministry documentation

The review of the Ministry's systems and practices will include:

- Strategic plans, work programmes and operational plans (since the IDCCR Act came into force).
- Policies, procedures and guidance.
- Quality assurance processes.
- Reports on compliance.
- Contracts.
- Collaboration and engagement with other parties.
- Detailed information about:
 - individual case studies;
 - the services provided by each of the NIDSS/RIDSS facilities; and

- actions taken by the Ministry in response to concerns raised by DHB NIDSS/RIDSS providers.

Meetings

In addition to reviewing Ministry records, the investigation team will meet with key Ministry staff with responsibility for the following aspects of the Ministry's systems and practices concerning intellectual disability services under the HCF:

- leadership, policy and strategic direction;
- organisational/operational performance;
- contract management;
- quality assurance; and
- operational matters concerning the HCF.

As noted above, information obtained during the meetings is subject to the secrecy requirements of section 21 of the Ombudsmen Act and will not be disclosed except in accordance with that section. These meetings may be recorded and will generally take between 1-2 hours.

Scheduling of meetings

There will be an initial meeting with the Ministry shortly after the investigation is notified to discuss the Terms of Reference and the case study approach to this investigation. The investigation team will also seek an overview of the information the Ministry holds in relation to the matters under investigation. Shortly after the initial meeting, a request for relevant information held by the Ministry will be made. Any further meetings will be scheduled after the Ministry has provided the information requested and it has been analysed by the investigation team.

Interviews

The investigation team may decide to interview certain Ministry staff, in order to obtain as much relevant information as possible about the matters under investigation. These interviews will be digitally recorded. The Ministry will be advised which staff members are to be interviewed. The investigation team will then contact the interviewees direct to schedule the interview. Any Ministry staff selected as interviewees will be provided with information about the interview process, including the legal framework and the purpose of the interview. It is envisaged that interviews will take around 1 to 2 hours. Again, information obtained during the interviews is subject to the secrecy requirements of section 21 of the Ombudsmen Act and will not be disclosed except in accordance with that section.

Third party information

The investigation team will also gather relevant information from third parties involved in the intellectual disability sector, in order to add context to the information provided by the Ministry. In particular, the investigation team will obtain detailed information from NIDSS/RIDSS facilities about the case studies and related issues. Case study participants and their families/representatives will be included in this engagement. The investigation team will also contact District Inspectors and other key stakeholders, and also seek input from an independent expert in the field of Intellectual disability. For the avoidance of any doubt, the Ministry is the only agency under investigation by the Chief Ombudsman. However, DHBs contracted to provide NIDSS/RIDSS facilities will be also advised of the investigation.

Reporting

Draft report

The draft report will outline the Chief Ombudsman's provisional opinion, including the evidence relied on and the analysis undertaken in forming that opinion. Where relevant, the draft report will identify any suggestions and/or recommendations that may be made to improve the Ministry's practices. The draft will be provided to the Chief Executive of the Ministry for comment. Relevant extracts will be provided to the individuals and their families/representatives who are featured as case studies in the report. The Chief Ombudsman may also seek comment from third parties who are referred to in the report. Third parties will be given an opportunity to comment if it appears that they may be adversely affected by, or the subject of adverse comment in, an Ombudsman's opinion or recommendations.⁵

Final report

Comments received on the draft report will be considered for amendment of, or incorporation into, the final report. The Chief Ombudsman will provide the final report to the Chief Executive of the Ministry. The final report will be published on the Ombudsman's website and tabled in Parliament.

After the investigation

Following completion of the investigation, there will be ongoing monitoring of actions taken by the Ministry in response to any suggestions or recommendations by the Chief Ombudsman. The Chief Ombudsman will also conduct a review exercise as part of his Continuous Practice Improvement programme. The Chief Ombudsman will seek the views of the Ministry's senior managers on their experience of this systemic improvement investigation, its value and relevance to improving their work practices, and how future investigations may be improved when applied to other agencies.

⁵ Sections 18(3) and 22(7) of the Ombudsmen Act 1975.

TIMETABLE OF INDICATIVE DATES

Date	Action
January 2019	Formal notification of investigation and Terms of Reference sent to Ministry with a request for meeting
February 2019	Initial meeting with Ministry to discuss TOR
March–April 2019	Information requests sent to Ministry, DHBs and third parties
May 2019	Ministry and other parties respond to information requests
June–July 2019	Analysis of information
August–October 2019	Further information gathering including interviews with Ministry/third parties
November–December 2019	Analysis of all information gathered
February–March 2020	Provisional report sent to Ministry

Mason Clinic Redevelopment – Programme Business Case

WAITEMATA DISTRICT HEALTH BOARD

Mason Clinic Redevelopment Programme

Programme Business Case

FINAL

August 2019

Mason Clinic Redevelopment – Programme Business Case

Document Version:	Final v1.0 (1 August 2019)
Business Case Owner:	Roger Perkins – Director, Strategic Capital Programme Group
Input Provided By:	<p>Waitemata DHB Roger Perkins – Director, Strategic Capital Programme Group Jeremy Skipworth – Clinical Director, Mason Clinic Nigel Ellis – Strategic Capital Programme Group Paul Stanbridge – Project Director</p> <p>PwC Mark Robinson Craig Rice</p> <p>Other Mungo Smith – MAAP Rachael Rush – Klein Stephen Davies-Howard – Davies Howard Group</p>
Business Case endorsed by:	<p>Waitemata DHB programme Steering Group Waitemata DHB programme Senior Responsible Owner Waitemata DHB Executive Leadership Team Waitemata DHB Board Regional Mental Health Clinical Network Regional Capital Group Regional Executives Forum Regional Governance Group</p>
Next step:	Capital Investment Committee

Waitemata DHB has developed this business case with the assistance of PwC. It has been peer reviewed by Davies Howard Group.

Mason Clinic Redevelopment – Programme Business Case

Glossary

ARFPS	Auckland Regional Forensic Psychiatry Service
CEO	Chief Executive Officer
CIC	Capital Investment Committee
DBB	Design, Bid, Build
DHB	District Health Board
ECI	Early Contractor Involvement
ECIB	Elective Capacity and Inpatient Beds
ILM	Investment Logic Map
LTIP	Long Term Investment Plan
MBIE	Ministry of Business, Innovation and Employment
NRA	Northern Regional Alliance
NRLTIP	Northern Region Long Term Investment Plan
PBC	Programme Business Case
PMO	Programme Management Office
PSO	Portfolio Support Office
SCPG	Strategic Capital Programme Group
SRO	Senior Responsible Owner
TEC	Tertiary Education Commission

Mason Clinic Redevelopment – Programme Business Case

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Mason Clinic Redevelopment – Programme Business Case

1. Executive Summary

Waitemata District Health Board (DHB) provides forensic mental health services to residents of the Northern Region, and forensic intellectual disability services for those north of Taupo, on behalf of the other regional DHBs, at the Mason Clinic in Point Chevalier, Auckland.

The Northern Region DHBs (Northland DHB, Waitemata DHB, Auckland DHB and Counties Manukau DHB) collectively serve a population of 1.9m, which is projected to grow significantly in the future.¹

This is a Programme Business Case (PBC) for Waitemata DHB's Mason Clinic redevelopment programme. This programme is addressing both capacity and capability issues with the Mason Clinic's existing facilities.

Waitemata DHB is about to acquire 2.8ha of land adjacent to the existing campus, to better enable the redevelopment, and to provide the Mason Clinic with a land footprint which is big enough to cater for demand in the current location for the foreseeable future.

This land acquisition has created the opportunity to co-locate core forensic and related services, if that is deemed appropriate at some point in the future. This PBC accounts for that possibility, but does not provide any policy recommendations. For the purposes of the master plan and this PBC, we have assumed that policy discussions will lead to the Mason Clinic being directed to provide all additional and enhanced services within five years.

This PBC seeks approval to develop a series of tranche-based business cases, beginning with a first tranche for which \$60m capital funding has been prioritised (although an investment in the order of \$160m is necessary to meet our urgent needs).

The redevelopment of the existing facilities at the Mason Clinic, including the provision of additional capacity, is consistent with the Northern Region Long Term Investment Plan (NRLTIP), national and regional mental health service strategies, and site master planning. It also contributes to wellbeing under the Government's Living Standards Framework. This PBC has been fully consulted on within the Northern Region, and has been endorsed by the Regional Capital Group, Regional Executives Forum and Regional Governance Group.

1.1 Background

The capacity and capability issues at the Mason Clinic have been evident for many years. Planning for a redevelopment of the Mason Clinic, to provide both additional capacity and fit-for-purpose facilities, has been happening for some time.

But uncertainty over whether the Mason Clinic would be able to remain, and potentially expand, on its present site slowed down site master planning and the development of this PBC.

- In 2016 (when approving the Te Aka unit), the Ministers of Finance and Health recognised that any significant expansion of the Mason Clinic to meet predicated long-term demand would be dependent on acquiring land from Unitec.
- Negotiations between Waitemata DHB and Unitec in 2016 proved unsuccessful. Although Unitec was interested in divesting surplus land earmarked for residential housing and mixed use development, it was concerned about the Mason Clinic remaining on its current site due to the impact on land values. In response, the Ministers of Health, Finance and Tertiary Education, Skills

¹ Statistics New Zealand (2017), Subnational population projections.

Mason Clinic Redevelopment – Programme Business Case

and Employment directed officials to investigate the options for the future of the Mason Clinic from a whole of government perspective.

- An independent report commissioned by the Ministry of Business, Innovation and Employment (MBIE) and the Tertiary Education Commission (TEC), and completed in November 2016, considered a number of different site location options.² It found that, from a whole of government perspective, the Mason Clinic should remain at its current location, with the option to expand through acquisition of land from Unitec. The Ministers of Health and Tertiary Education, Skills and Employment agreed with this recommendation and, in May 2017, asked Waitemata DHB and Unitec to negotiate on suitable terms. While some progress was being made, in November 2017, Unitec switched its attention to discussions with MBIE for the sale of land for social housing purposes.
- In March 2018, Cabinet agreed in principle to the Ministers of Finance and Housing and Urban Development approving the acquisition of 29.3ha of land (adjacent to the Mason Clinic) from Unitec for State housing purposes. Cabinet noted that, following acquisition of the land, MBIE would seek to conclude as soon as possible an agreement with Waitemata DHB for the transfer of 2.8ha to allow for the expansion of the Mason Clinic, "*unless a suitable future alternative site for the functions of the Mason Clinic can be found*".

While these discussions took place, the urgent issues with the Mason Clinic facilities remained. In response, the Te Aka unit was constructed and the replacement for the Tanekaha unit was approved (and is now under construction), in advance of the formal preparation of a redevelopment programme.

The uncertainty was effectively resolved in April 2019 when Ministers approved the transfer of 2.8ha of land to Waitemata DHB. The land transfer is expected to be finalised in August 2019.

This history, and in particular the recent land transfer, effectively limits the scope of programme-level solutions in this PBC to those which involve provision of services on the current Mason Clinic site.

1.2 Strategic case

There are three key problems with the Mason Clinic's existing inpatient facilities.

1. Service capacity is insufficient to meet future demand

The Mason Clinic does not currently have the capacity to be able to cater for the forecast future demand for forensic mental health and intellectual disability services. Additional capacity is required for us to continue to provide these services to all patients in the region who require them. Furthermore, if it is deemed appropriate that the Mason Clinic should in the future provide additional services for high and complex needs patients or youth forensic services, this will require even more additional capacity.

The inpatient facilities are at capacity today, and the 15-bed unit currently under construction will be full upon opening. There is no alternative facility in the region to provide forensic mental health services, and inadequate capacity results in patients being inappropriately held in prison.

The demand for inpatient forensic mental health and intellectual disability services in the Northern Region is growing rapidly. By 2043, over 1.1m more people are projected to live in the Northern Region, with a consequent projected increase in the prison muster and court cases.

² Zusammen Limited (Nov 2016), Mason Clinic Land Options.

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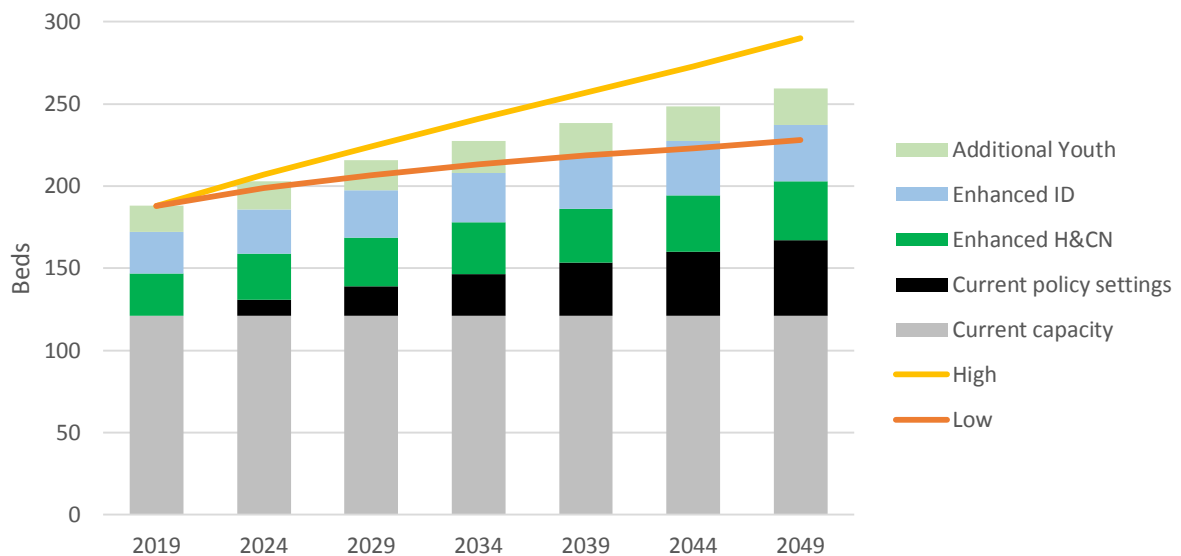
In addition to an increasing requirement for services generally, demand for dedicated forensic intellectual disability beds is already well in excess of the supply. This is leading to a need for additional separate specialist facilities for these patients.

Translating population, prisoner and court growth into demand for forensic mental health services indicates that by 2049, in addition to the unit currently under construction:³

- The continued provision of our current services, in line with current policy settings, would require 46 additional inpatient beds, on top of the existing 121 beds, for a total of 167 beds.
- Enhancing the service for adult high and complex needs patients would require up to 36 additional beds.
- Enhancing the service for forensic intellectual disability would require up to 34 additional beds.
- Adding a youth forensic service, which caters for all demand in the Northern Region, would require up to 22 additional beds.
- Providing all the additional and enhanced services noted above would require up to 117 additional beds, bringing the total bed requirement for the Mason Clinic to 259 beds.

Note: Some of the above elements are obviously dependent on policy decisions by the Ministry of Health. They are included here to describe what capacity *would* be required were such decisions to be taken.

Figure 1 Forecast bed demand, for different policy settings



2. Building fabric deficiencies are putting patient and staff safety and service continuity at risk

Four buildings at the Mason Clinic are failing significantly, suffering from weathertightness and leaky building issues – Kahikatea, Rata, Kauri and Totara. They need to be decommissioned as soon as possible.

Water ingress has been, and is, causing internal damage and compromising the integrity of the buildings. While this has been mitigated by ongoing repairs, the units have deteriorated to the point where they are

³ PwC (June 2019), Mason Clinic demand forecasting.

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at risk of developing *Stachybotrys* fungus in some wall cavities.⁴ We have recently decommissioned and demolished the Tanekaha unit, but these four remain in operation.

Three monthly air testing continues. Recent tests confirmed that the presence of the fungus is currently at safe levels. However, this situation may not continue as the buildings are coming to the end of their design life and are not weathertight. Higher readings could require immediate decanting of one or more of the units.

This creates an unacceptable risk to the health of patients, their families and staff. This could render the buildings unfit for use, threatening the continued ability to provide forensic mental health services from the existing buildings.

The cost of maintaining or refurbishing the existing buildings is greater than the cost of replacement. Accordingly, a replacement programme is urgently needed.

There is no alternative provider of forensic mental health services in the region. Therefore, the potential for disruption to service provision at the Mason Clinic puts at risk the Northern Region's ability to provide this service to all patients in the region on a sustainable basis.

3. Facility design does not meet service requirements or support contemporary models of care

Most of the Mason Clinic facilities were designed to support a different model of care to that which we operate today. This is limiting our ability to safely and adequately provide forensic health services in line with best practice and our model of care.

The development of contemporary models of care for forensic mental health and intellectual disability services is changing the way those with mental needs or intellectual disabilities in the criminal justice system are assessed, treated and rehabilitated. This model of care requires different facilities to those we currently have – with a greater focus on rehabilitation and reintegration without the use of restrictive interventions, and where services are integrated across the care continuum of security needs.

With the exception of Te Aka and the unit currently under construction, the design and configuration of the existing facilities no longer meet the needs of patients. In particular:

- There are not enough rooms for assessment, treatment and rehabilitation activities.
- Communal ablution blocks adversely impact patient experience, increase staffing requirements, and will make it difficult to phase out the use of night safety procedures which the Ministry of Health has indicated must occur before 2022.
- Rooms are not big enough to adequately cater for long term residents, adversely impacting recovery and clinical outcomes.
- Some minimum secure units have seclusion areas, but these are not needed in those units.
- No unit has a sufficient security level to provide safe provision of care for high security patients.
- Units that provide complementary clinical services are not physically linked together. This limits the ability to provide an integrated service and promote continuity of care, and reduces the efficiency of staff work.
- In an environment where medium density residential housing is expected to soon occupy the land around the Mason Clinic, for privacy and safety reasons, Mason Clinic buildings would best be

⁴ *Stachybotrys* is a toxic mould which is extremely dangerous to humans. It can cause serious health problems, including respiratory problems, skin inflammation, haemorrhage, damage to internal organs, mental impairment, irritation of mucous membranes, tiredness, nausea and immune system suppression.

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sited around the periphery of the campus. This would provide a visual and physical barrier to the community, and create a shared community zone for service users with ground access.

1.3 Economic case

Proposed redevelopment

Our proposed redevelopment of the Mason Clinic involves:

- The construction of a number of modern single and multi-storey units, over the land under the units to be demolished and the newly acquired land, to provide capacity for up to 246 beds.
- Demolition of the existing units with serious weathertightness issues and which are no longer fit for purpose – Kahikatea, Rata, Kauri and Totara – and some aging support buildings such as Kowhai and the workshop.
- Retention, and potential upgrade, of the other existing inpatient units and buildings.
- The construction of a series of shared support facilities to accommodate front-of-house and security, judicial, therapeutic, wellness, administrative and non-clinical support functions.
- Provision of additional on-site carparking for staff and visitors, together with access for emergency and support traffic.
- An increase in total building footprint from 30% of the site to 34%, while at the same time almost doubling the inpatient capacity.
- The use of three main stages of work, each of which may have sub-stages, with redevelopment beginning from the Northern end of the campus.

Stage 1

The first stage will involve replacing the buildings with weathertightness issues with new facilities, with no change in overall capacity.

- Two new two-storey units will be built on the newly acquired land at the north end of the site. Each unit will have 30 beds, 15 on each level (60 beds in total), and will be a combination of minimum (T3), medium (T2) and high (T1) security levels.
- The Kahikatea, Rata, Kauri and Totara units will be decommissioned. This will remove 60 beds currently in use.⁵
- A three-storey shared activity and support building, including two-storey entry court, front of house, judicial activities, drop-off, access and carparking will be constructed on the newly acquired land, and the start of the central secure garden will be created.

This is a necessary first step before additional capacity can be contemplated.

Stage 2

The second stage will involve the demolition of the decommissioned units, the provision of urgently needed additional capacity, and the provision of specialist facilities for additional and enhanced services.

- The Kahikatea, Rata, Kauri and Totara units will be demolished.

⁵ It is assumed that, when the unit under construction is commissioned, the operational capacity of Kahikatea will be reduced from 20 to 15 beds.

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- Two new facilities for forensic mental health patients will be built:
 - A two-storey unit, with 30 beds and administration spaces, similar to those built in Stage 1. It is expected to cater for adult high and complex demand patients, in addition to forensic mental health patients, and be cited on the western side of the campus.
 - A single-storey unit, with nine specialist step-down beds, next to the existing Rimu unit.
- If deemed appropriate, two specialist units will be built to provide to provide additional and enhanced services:
 - A two-storey specialist unit for forensic intellectual disability patients, next to the Pohutukawa unit on the current site of the Kowhai and workshop buildings.
 - A two-storey specialist unit for youth forensic patients, on the newly acquired land at the southern end of the campus.
- The specific numbers of each type of unit, their specific location within the campus, and the order in which each unit is built, will be determined during the business case process for Stage 2. This will be based on updated demand forecasts for each service, and any further direction from central agencies regarding the provision of youth forensic services and additional services for high and complex needs patients.
- These facilities could be constructed all at one time, or they could be staged. At least one of the two forensic mental health units will be needed urgently, but timing for the specialist youth and intellectual disability units will depend on when (and if) they are deemed appropriate. As such, Stage 2 may be delivered in multiple sub-stages.

For the purposes of the master plan and this PBC, we have assumed that policy discussions will lead to the Mason Clinic being directed to provide all additional and enhanced services within five years, and as such the provision of units for these services are included with Stage 2 (rather than delayed until Stage 3).

- If all such facilities set out above are constructed, this will involve the addition of 77 beds during this stage, increasing the total capacity of the Mason Clinic from 121 to 198 beds.
- Additional support buildings and carparking will be constructed, along with further development of the central secure garden. This will include the return of community facilities removed during Stage 1.

Stage 3

The third stage will involve adding further additional capacity over time, as required by regional demand.

- The types of units, the specific numbers of each, their specific location within the campus, and the order in which they are built, will be determined during the business case process for Stage 3. This will be based on updated demand forecasts for each service, the amount of further capacity which is ultimately provided during Stage 2, and any further direction from central agencies regarding the provision of youth forensic services and additional services for high and complex needs patients.
- The current master plan envisages the potential addition of 48 beds during this stage (over and above those added during Stage 2), increasing the total capacity of the Mason Clinic to 246 beds. The master plan envisages these units to comprise:
 - one additional 30-bed unit for forensic mental health patients, on the western side of the campus

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- one 12-bed unit for forensic intellectual disability patients, on the western side of the campus (assuming this is required by the Ministry of Health)
- an expansion of the youth unit built in Stage 2.
- These units are envisaged to be constructed in multiple sub-stages, based on regional demand.
- Additional support buildings and carparking will be constructed, and the central secure garden area will be finished.

The four figures below show maps of the Mason Clinic at present, and after Stages 1, 2 and 3.

Figure 2 Mason Clinic at present (including unit under construction)

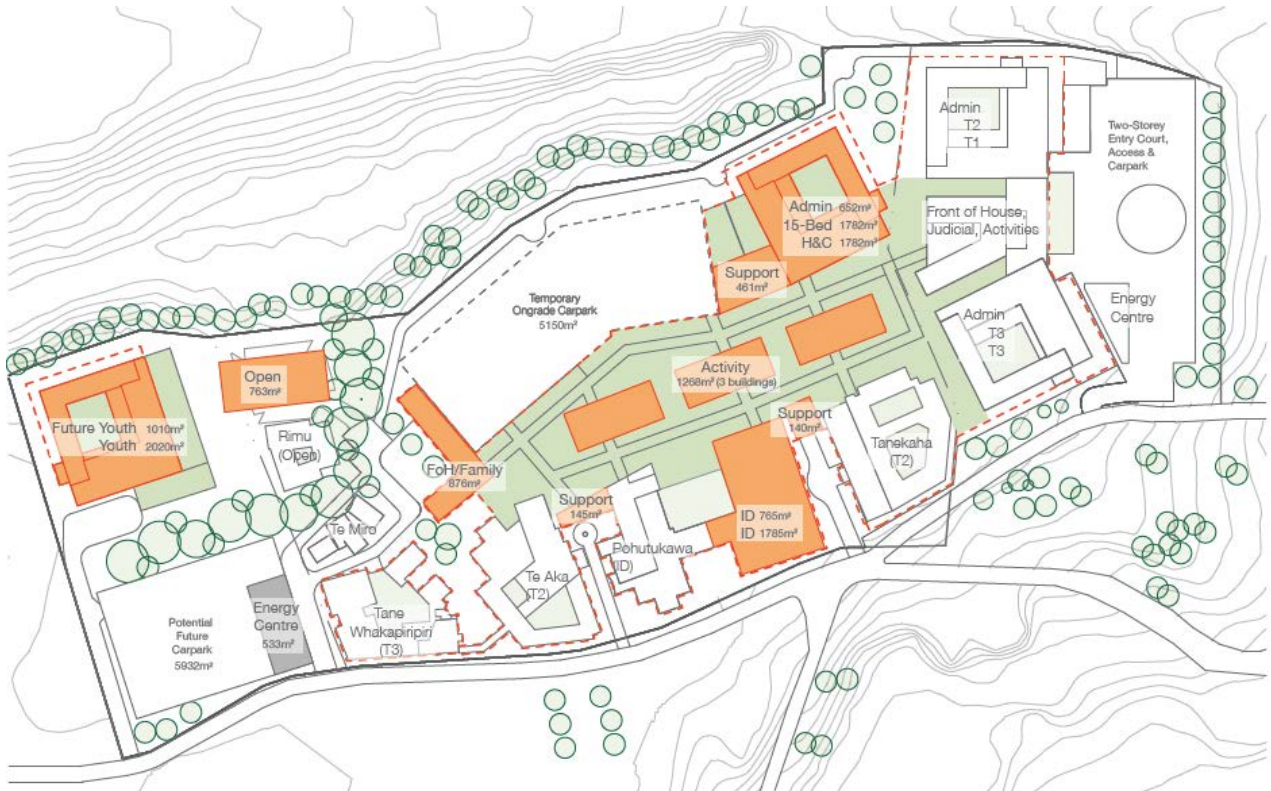


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Figure 3 Future Mason Clinic after Stage 1



Figure 4 Potential future Mason Clinic after Stage 2



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Figure 5 Potential future Mason Clinic after Stage 3



Funding tranches

The tranches developed for funding and business case purposes will be derived from the stages and sub-stages noted above. But they will also be contingent on funding availability.

Proposed Tranche 1

We propose that Tranche 1 includes all of Stage 1. This is expected to cost in the order of \$160m in capex.

Alternative Tranche 1

We understand that only \$60m in capital funding has currently been prioritised for Tranche 1 of the programme. This will be insufficient to complete Stage 1.

If only \$60m (or a similar amount) is available for Tranche 1, then this tranche will necessarily only comprise a small part of Stage 1. Specific options for a smaller solution will be developed as part of the business case for Tranche 1, but a solution of this scale will inherently only be able to provide, at most, one of the two inpatient units and significantly reduced support, activity and carparking spaces.

While conceivable, we consider that attempting to deliver Stage 1 in multiple tranches (beginning with a first tranche in the order of \$60m), is a significantly inferior solution. In particular:

- In order for the first new inpatient unit to be functional, Tranche 1 also needs to include the central buildings, site establishment, infrastructure works, and the main entry drop off area. This means that as much as 75% of the Stage 1 works may need to occur in a smaller solution. Our current analysis indicates that this will not be possible within a \$60m capital envelope.
- It would require two of the failing units to remain in operation for a number of years longer than necessary. These four units are already exposed to a significant risk of patient and staff harm,

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which threatens our ability to provide services on an ongoing basis, and we consider that further delay to their replacement to be an unacceptable solution.

- It delays the time when we are able to reconfigure the horizontal infrastructure on the western side of the campus.

Options analysis

This programme has been assessed against a range of other options.

Programme-level options

The preferred approach of facility replacement and redevelopment on the current site was considered against two other high-level options:

- Refurbishing the existing facilities, and adding capacity on the newly acquired land
- Relocating the Mason Clinic service to an alternative location.

There are a number of reasons why replacement and redevelopment is preferred to refurbishment. Firstly, the cost of maintaining and refurbishing the existing buildings is greater than the cost of replacement. Secondly, refurbishment would not be able to fully address the weathertightness, and hence these buildings would continue to carry an inherent risk of becoming a hazard. Thirdly, refurbishment would not allow us to increase capacity on the existing campus footprint (only on the newly acquired land), nor allow us to improve the design and configuration of the units.

The potential option of relocating the Mason Clinic service elsewhere has been considered in depth by Waitemata DHB and central agencies in recent years, and has been rejected. The recent acquisition of land adjacent to the existing campus allows us to focus future thinking on the current (and now expanded) Mason Clinic site.

New inpatient building typology

After much consideration – a separate Ministry of Health study has been carried out on the topic – we now propose the use of two multi-storey units to single-storey units, for the redevelopment of the Mason Clinic. This is for the following reasons:

- It enables a greater maximum bed capacity within the constrained footprint of the site. Unlike some other mental health facilities in New Zealand, land constraints are a critical consideration for the Mason Clinic.
- It allows easier decanting and better staging of the programme, with one new unit able to replace two existing units.
- It utilises the sloping topography of the newly acquired land at the north of the site, with two-storey units in this part of the campus effectively able to provide ground level access from both inpatient floors.
- It enables additional space to be used for a central secure garden area.
- It increases options for locating on-campus carparking in the short term.
- It enables support spaces to be used more efficiently.
- Multi-storey facilities have operated successfully in a number of international locations, and are able to support contemporary models of care.

The main disadvantage of a multi-storey solution is that residents of upper levels have reduced access to gardens – with smaller gardens and balconies on those floors. However, this can be offset by having a

Mason Clinic Redevelopment – Programme Business Case

larger common central garden, and designing the security levels such that those on the upper floors are also those who have the greatest allowed access to the central secure garden.

Staging

The programme will be completed in stages to ensure that there are no additional capacity constraints due to the temporary closure of buildings. Furthermore, a staged approach allows us to retain flexibility to adjust the programme if necessary.

Initial works

The only feasible option for Stage 1 is to build new inpatient units on the land which is shortly to be acquired at the north end of the site.

- We must continue to provide inpatient services during the redevelopment, and reducing capacity for a period is not a viable option. Hence it is not possible to decommission an existing building before a new one is built. Therefore, the first step in the redevelopment programme must involve constructing a new unit or units.
- There is no space of a sufficient size within the existing 3.9ha campus to construct a new unit. Therefore, the newly acquired land must be used.
- The Northern site is preferred to the South for two reasons:
 - Its natural sloping topography lends itself to the construction and placement of multi-storey inpatient units, being effectively able to provide ground-level access to both inpatient floors.
 - The Southern site is best suited to future rehabilitation units with lower security, due to its proximity to the Mahi Whenua sanctuary garden and a water stream partially running through from the existing site. This waterway divides the campus, and does not work well with the concept of a 'central secure garden' for core forensic services.

Staged demolition

The proposed programme replaces the existing failing units before adding capacity, and demolishing all the failing units at the same time.

However, an alternative approach could involve adding 30 beds as part of Stage 1, and then replacing the existing units while maintaining this higher capacity level. This would require an additional stage of demolition and decanting – for example, Kauri and Totara could be demolished and subsequently replaced on the same footprint, but Rata and Kahikatea only demolished once the new unit was built on the Kauri/Totara site. This approach is more complex and would require additional staging. It would only be warranted if the additional capacity was needed more urgently than it could be provided under the former option.

The former approach is preferred at this time, given the urgency with which the existing units need to be replaced, and the unit currently under construction is providing additional capacity in the short term. However, this will be reconsidered through the development of the tranche-based business cases.

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1.4 Commercial case

It is currently expected that the individual projects within each tranche will be procured using a traditional design bid build (DBB) approach. This approach has been successfully used for the recent developments at the Mason Clinic, and is also being used for the ECIB project. There is no reason to use an alternative approach for this programme.

Each tranche will be procured separately. Within each tranche, some projects may be procured together (e.g. the two inpatient units in Stage 1) and others will be procured separately (e.g. the carpark in Stage 1).

Consideration will be given to methods of using contractor resource as early as possible. The two options considered for ECIB were a traditional early contractor involvement (ECI) method and splitting the procurement into an early works and main works package (with the latter approach preferred).

Procurement of operational requirements will be managed through existing DHB processes.

The procurement process will be designed such that it can contribute to increasing the size and skill level of the domestic construction sector workforce and provide employment opportunities to targeted groups, in accordance with direction from Government.

1.5 Financial case

Expected costs

A detailed costing has yet to be prepared for the programme as a whole. Cost estimates will be prepared for each of the programme tranches as they are developed.

The programme will begin with a first tranche, for which \$60m in capital funding has been prioritised, although an investment in the order of \$160m is necessary to meet our urgent needs. The business case for Tranche 1 of the programme will include an updated version of this estimate, with an accompanying breakdown.

Funding approach

Waitemata DHB has insufficient reserves to fund this programme in its entirety. While the DHB has used demand management initiatives to delay the need for this investment, we are not able to support the investment through a financial capital contribution, and accordingly Crown equity is required.

The funding of this programme has been discussed with the Ministry of Health and Treasury. We understand that the Government has prioritised \$60m of capital funding for the first tranche of this programme, while funding for subsequent tranches is yet to be prioritised.

Funding for the direct operating costs associated with the new units is expected to be provided by the Crown as per the current method for funding forensic mental health and intellectual disability services, that is via the allocated revenue from the Ministry of Health.

Any increase in capital charge and depreciation that will accrue to the DHB's profit and loss account will not be affordable until national pricing reflects these indirect costs, a lag of at least two years under the current funding model. We understand that no capital charge will be levied on DHB capital projects for the foreseeable future, and we support this decision. Waitemata DHB also requests that a grant be given for the first two years to compensate for the additional depreciation charge incurred.

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1.6 Management case

Programme timeline

Table 1 outlines the high-level indicative timetable for the programme.

Table 1 Indicative programme schedule

Task	Indicative date
Programme Business Case	Aug 2019
Tranche 1 (all of Stage 1)	
Business Case	Sept 2019
Design	Early 2020 – Mid 2021
Construction	Mid 2021 – Mid 2023
Tranche 2 (initial elements of Stage 2)	
Business Case	Late 2020
Design	Late 2020 – End 2021
Construction	Early 2022 – End 2023
Subsequent tranches	TBC

Programme governance

Waitemata DHB's Board and Chief Executive Officer (CEO) have overall responsibility and accountability for the programme. The Board and CEO are supported by the Deputy CEO, Senior Responsible Owner (SRO) and Programme Director by way of oversight across general operations.

- The Executive Leadership team, and in particular the Deputy CEO, provides oversight of all strategic capital programmes. The Deputy CEO sits on the Programme Steering Group.
- The SRO for the programme is the Director, Strategic Capital Programme Group (SCPG).
- A Programme Steering Group has governance responsibility for ensuring that the programme is developed and managed effectively to deliver the expected outcomes, on time and to budget. The Steering Group is chaired by the SRO, and reports directly to the CEO.
- A Programme Director will be appointed later this year. Project Managers will be appointed in due course for individual projects within each tranche.
- The SCPG is effectively the programme management office (PMO), and is the forum for the Programme Director to oversee progress and provide leadership and direction for the programme.
- The service change lead for the programme is the Clinical Director of the Mason Clinic.

The DHB has an established programme to build portfolio and project management capability implementing a structured Portfolio Management, Programme Management and Project Management (P3M3) methodology and has invested in a centralised Portfolio Support Office (PSO) and PMO to support the implementation of the programme. The PSO process uses existing organisational, quality and reporting structures to support project and change management.

Mason Clinic Redevelopment – Programme Business Case

Risks

The most notable programme risks are:

- Sufficient funding is not available to deliver the proposed investments, in the timeframe required to eliminate unacceptable risk of service disruption and ensure capacity is sufficient to maintain service levels.
- The projects cannot be delivered in the timeframe required, because of either difficulty accessing contractor resource (at reasonable costs) and/or a lack of internal DHB resources to manage the projects.
- Direction from central agencies regarding the provision of additional services for high and complex needs patients and/or youth forensic services is unclear, susceptible to change, or not provided in a timely way.

Each item reflects the overall risk of delay to the delivery of the programme. A significant delay will have the following impacts, both of which limit the programme's ability to achieve the investment objectives:

- Increased cost when the projects are eventually delivered (as a result of increased cost escalation)
- An unacceptable risk of major disruption to service delivery, until such time as the projects are delivered.

1.7 Recommendations

Waitemata DHB recommends that CIC:

1. **Notes** that the Mason Clinic has an urgent need to remediate some of its existing facilities, and that it will need additional capacity in order to continue to provide the same level of services in the future.
2. **Approves** the development of a programme of tranche-based business cases to support the long-term development of the Mason Clinic
3. **Supports** the development of a Single-Stage Business Case for Tranche 1 of the programme, for which \$60m Crown capital funding has been prioritised, although an investment in the order of \$160m is necessary to meet our urgent needs.

Mason Clinic Redevelopment – Programme Business Case

2. Introduction

Waitemata DHB provides forensic mental health services to residents of the Northern Region, and forensic intellectual disability mental health services for those north of Taupo, on behalf of the other regional DHBs, at the Mason Clinic in Point Chevalier, Auckland.

The Northern Region DHBs (Northland DHB, Waitemata DHB, Auckland DHB and Counties Manukau DHB) collectively serve a population of 1.9m, which is projected to grow significantly in the future.⁶

This is a PBC for Waitemata DHB's Mason Clinic redevelopment programme. This programme is addressing both capacity and capability issues with the Mason Clinic's existing facilities.

The existing Mason Clinic facilities are operating at capacity, and cannot accommodate any growth in demand. There is no alternative facility in the region to provide forensic mental health services. To support the forecast growth in population and prison muster, additional inpatient forensic mental health capacity is required.

In addition, the Mason Clinic facilities need replacing and reconfiguring. Most notably:

- Four buildings are failing significantly, suffering from weathertightness and leaky building issues which, left untreated, will lead to unacceptable health issues.
- The facilities which are failing were all designed for a different model of care to what we have today. The designs of the units, and their configuration within the campus, do not meet our service requirements or support contemporary models of care.

Waitemata DHB is shortly to acquire 2.8ha of land adjacent to the existing campus, to better enable the redevelopment, and to provide the Mason Clinic with a land footprint which is big enough to cater for demand in the current location for the foreseeable future.

This land acquisition has created the opportunity to co-locate core forensic and related services, if that is deemed appropriate at some point in the future. This PBC accounts for that possibility, but does not provide any policy recommendations. For the purposes of the master plan and this PBC, we have assumed that policy discussions will lead to the Mason Clinic being directed to provide all additional and enhanced services within five years.

This document sets out the strategic rationale for change, explores options at a programme level and establishes the preferred way forward. It identifies possible tranches and timeframes, as well as costs and funding sources for the programme.

This PBC seeks approval to develop a series of tranche-based business cases, beginning with a first tranche for which \$60m capital funding has been prioritised (although an investment in the order of \$160m is necessary to meet our urgent needs).

This document has been prepared in accordance with Treasury's Better Business Case guidelines. This PBC has been fully consulted on within the Northern Region, and has been endorsed by the Regional Capital Group, Regional Executives Forum and Regional Governance Group.

⁶ Statistics New Zealand (2017) Subnational population projections.

Mason Clinic Programme Business Case – Strategic Case

3. Strategic Case

3.1 Background

Waitemata DHB and the Mason Clinic

Waitemata DHB provides secondary hospital and community services, primarily for the communities of Auckland's North Shore, Waitakere and Rodney areas. It is one of four DHBs within the Northern Region. It has both the largest, and fastest growing, population of any DHB in NZ.

Waitemata DHB has three main clinical sites – North Shore and Waitakere Hospitals, and the Mason Clinic forensic psychiatric campus.

The Auckland Regional Forensic Psychiatry Service

The Auckland Regional Forensic Psychiatry Service (ARFPS) was established in 1989 following the Mason Inquiry into New Zealand's forensic mental health provision. It provides an integrated forensic mental health service to the Northern Region's courts, prisons and general mental health services. Waitemata DHB provides the ARFPS on behalf of the other Northern Region DHBs.

The key services the ARFPS provides are:

- Court liaison services
- Prison mental health services
- Community follow-up services
- Liaison services to other mental health services
- Inpatient service for people with mental illness
- Inpatient and community forensic intellectual disability services.

The inpatient services are provided at the Mason Clinic. The core role of the inpatient service is to assess, treat and rehabilitate people with a mental illness or intellectual disability who are in the criminal justice system or are at high risk in the community.

The Mason Clinic

The Mason Clinic is a secure inpatient campus, located in Point Chevalier, Auckland. From this location, the ARFPS provides inpatient forensic mental health services to residents of the Northern Region, as well as forensic intellectual disability services for those north of Taupo.

The campus covers 6.7 hectares, after a recent acquisition of 2.8 hectares of land previously owned by Unitec.

As shown in Table 3, there are currently eight clinical units with 106 inpatient beds, and another 15-bed unit currently under construction, taking the total to 121 beds. The units include acute and rehabilitation units, with a range of security levels, as well as the only hospital-level secure unit for people with intellectual disabilities in Auckland.

The Te Aka unit, which opened in 2017, allowed us to decommission and demolish the 10-bed Tanekaha unit which had severe weathertightness issues. The 15-bed unit currently under construction will provide much needed additional capacity.

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Table 3 Mason Clinic inpatient facilities

Unit	Built	Capacity	Use	Security
Kauri	1992	15	Acute	Medium
Totara	1992	15	Acute & rehabilitation	Medium
Kahikatea	1993	15 ⁷	Rehabilitation	Minimum
Rata	1999	15	Rehabilitation	Medium
Rimu	2006	9	Rehabilitation	Step down open hostel
Tane Whakapiripiri	2006	10	Kaupapa Maori rehabilitation	Minimum
Pohutukawa	2006	12	Intellectual disability	Medium
Te Aka	2017	15	Kaupapa Maori rehabilitation	Medium
Total – current		106		
Unit under construction	TBC	15	Rehabilitation	Medium
Total – after current construction		121		

In addition to its core forensic mental health and intellectual disability services, the Mason Clinic treats some adult patients with high and complex needs, and on occasion youth forensic patients. These patients are treated in the Mason Clinic’s adult forensic units, rather than dedicated facilities.

- New Zealand has no dedicated facility for patients with high and complex needs who require secure care. At present, these patients are treated in a range of locations, including the Mason Clinic, prisons, hospitals, and community facilities.
- There is a National Youth Forensic facility in Wellington, but no similar facility in Auckland. The Northern Region’s youth forensic patients are currently treated at either the Wellington facility, the Mason Clinic, or at Starship Hospital.

The campus also has an administration centre, cultural centre, community outpatient base (for staff working in community teams, courts and prison mental health teams), a swimming pool and other associated outbuildings. Figure 6 shows a map of the Mason Clinic, including the building under construction.

⁷ Kahikatea has 20 physical beds, but it is assumed that, when the unit under construction is commissioned, its operational capacity will be reduced to 15 beds.

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Figure 6 Mason Clinic at present (including unit under construction)



The Mason Clinic redevelopment programme

The Mason Clinic redevelopment programme is addressing three issues with the current facility:

- Service capacity is insufficient to meet future demand.
- Building fabric deficiencies are putting patient and staff safety and service continuity at risk.
- Facility design does not meet service requirements or support contemporary models of care.

The programme includes the replacement of existing facilities and the construction of new buildings. 2.8 hectares of land has recently been acquired to better enable the redevelopment.

We expect that, with redevelopment and utilisation of the acquired land, we can increase on-site capacity to 246 beds, so that we can accommodate the future growth in both core and related services for at least 30 years.

Infrastructure assets are currently excluded from the scope of the programme, and are instead being provided through a separate 'Infrastructure Services Programme' (ISP) – the PBC for which is being submitted alongside this PBC. However, the boundaries between the scopes of the two programmes will be reconsidered when the Tranche 1 business case is prepared.

Planning preceding this business case

This PBC is informed by a substantial amount of planning which has already been undertaken.

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Redevelopment programme planning

The capacity and capability issues at the Mason Clinic have been evident for many years. Planning for a redevelopment of the Mason Clinic, to provide both additional capacity and fit-for-purpose facilities, has been happening for some time.

But uncertainty over whether the Mason Clinic would be able to remain, and potentially expand, on its present site slowed down site master planning and the development of this PBC.

- In 2016 (when approving the Te Aka unit), the Ministers of Finance and Health recognised that any significant expansion of the Mason Clinic to meet predicated long-term demand would be dependent on acquiring land from Unitec.
- Negotiations between Waitemata DHB and Unitec in 2016 proved unsuccessful. Although Unitec was interested in divesting surplus land earmarked for residential housing and mixed use development, it was concerned about the Mason Clinic remaining on its current site due to the impact on land values. In response, the Ministers of Health, Finance and Tertiary Education, Skills and Employment directed officials to investigate the options for the future of the Mason Clinic from a whole of government perspective.
- An independent report commissioned by the Ministry of Business, Innovation and Employment (MBIE) and the Tertiary Education Commission (TEC), and completed in November 2016, considered a number of different site location options.⁸ It found that, from a whole of government perspective, the Mason Clinic should remain at its current location, with the option to expand through acquisition of land from Unitec. The Ministers of Health and Tertiary Education, Skills and Employment agreed with this recommendation and, in May 2017, asked Waitemata DHB and Unitec to negotiate on suitable terms. While some progress was being made, in November 2017, Unitec switched its attention to discussions with MBIE for the sale of land for social housing purposes.
- In March 2018, Cabinet agreed in principle to the Ministers of Finance and Housing and Urban Development approving the acquisition of 29.3ha of land (adjacent to the Mason Clinic) from Unitec for State housing purposes. Cabinet noted that, following acquisition of the land, MBIE would seek to conclude as soon as possible an agreement with Waitemata DHB for the transfer of 2.8ha to allow for the expansion of the Mason Clinic, "*unless a suitable future alternative site for the functions of the Mason Clinic can be found*".

While these discussions took place, the urgent issues with the Mason Clinic facilities remained. In response, the Te Aka unit was constructed and the replacement for the Tanekaha unit was approved (and is now under construction), in advance of the formal preparation of a redevelopment programme. Business cases for those two projects were prepared and approved as standalone investments.

The uncertainty was effectively resolved in 2018, when Cabinet approved the transfer of 2.8ha of land to Waitemata DHB. The land transfer was finalised in 2019.

This history, and in particular the recent land transfer, effectively limits the scope of programme-level solutions in this PBC to those which involve provision of services on the current Mason Clinic site.

⁸ Zusammen Limited (Nov 2016), Mason Clinic Land Options.

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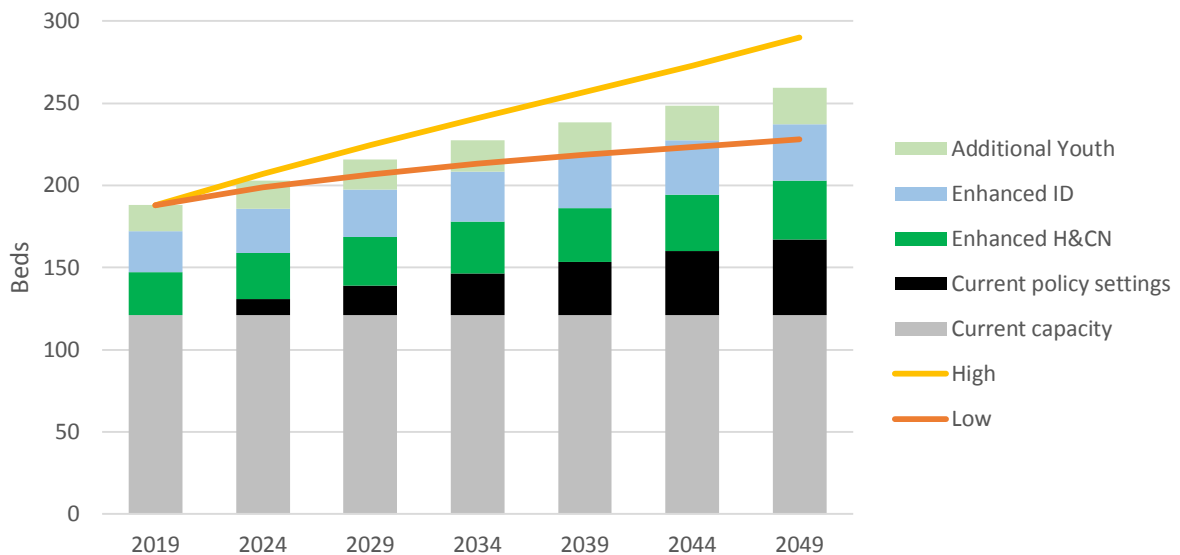
Future inpatient demand

The most recent analysis of future demand for forensic inpatient services was undertaken by PwC in 2019.⁹ The analysis applied a number of different scenarios, including different services provided and levels of service delivery.

The analysis showed that the Mason Clinic needs significantly more capacity than it currently has if it is to meet future demand for its current services. If the services and/or levels of service delivery are expanded, then even more capacity will be required.

As illustrated in Figure 7, demand for inpatient beds will naturally increase over time due to population growth (the black bars). If it is deemed appropriate that the Mason Clinic provides additional and/or enhanced services, this will further increase the overall demand for inpatient beds (the dark green, light blue and light green bars). The chart also shows high and low sensitivities, based on high and low population projections.

Figure 7 Forecast bed demand, for different policy settings



Northern Region Long Term Investment Plan

The NRLTIP has been developed to articulate the strategic direction for the Northern Region and to identify the investments necessary to ensure the ongoing delivery of high quality healthcare. This plan takes a 10 to 15 year view within the context of a 25 year planning horizon.

The NRLTIP provides the basis for analysis of future capital investment requirements within the region, and is the first truly regional assessment of future capacity requirements. It has been developed with a high level of engagement across the four DHBs and with other key stakeholders from the regional health system. The plan is particularly focused on pressing capacity and remediation issues affecting the region’s major hospital sites.

The NRLTIP sets out a package of future capital investments, including a redevelopment and expansion of the Mason Clinic.

⁹ PwC: (June 2019), Mason Clinic demand forecasting.

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Building condition assessments

The Mason Clinic buildings are of mixed material construction, comprising stucco plaster, fibre cement weatherboard and sheet panels, plywood, corrugated iron and concrete block.

An assessment of the campus in 2011 identified that several buildings were failing significantly, suffering from leaky roofs, guttering and exterior walls. An expert building survey was subsequently carried out by Cove Kinloch, to provide a report on what had by then become a 'leaky building' situation affecting nine different buildings to varying degrees.

Analysis was undertaken in 2019 by MaynardMarks to determine what life remains in the buildings, should no deferred maintenance / remediation to the buildings occur. MaynardMarks was unable to define a term for remaining life, as in its view, undertaking nothing is not a feasible option for any of the buildings.

The 2019 analysis found all the buildings have, to a varying degree, inherent risks to the users as a direct result of the potential for moisture ingress that can lead to both adverse indoor air quality and affect the structural capacity of certain building elements. MaynardMarks is of the view that this risk needs to be managed and the only way to address this is by way of incorporating a number of measures to mitigate service risks.

Development of contemporary models of care

The 'Mason Approach' document¹⁰ sets out our current model of care for forensic mental health patients. This approach has been developed over a period of time. It represents an evolution from the previous model of care, and focuses on rehabilitation and reintegration with reduced use of restrictive interventions, and with integrated services across the care continuum of security needs.

We have introduced new ways of working and patient care initiatives to implement this approach. We have also commissioned new fit-for-purpose inpatient units (Te Aka and the unit under construction). However, the design of the majority of the facilities does not fully support the delivery of the new model of care.

Location of future forensic inpatient services

As described above, the potential option of relocating the Mason Clinic service elsewhere has been considered in depth by Waitemata DHB and central agencies in recent years. For example, in 2016 Zusammen Limited assessed options of remaining on the current site, moving to another central urban location, or moving to a location outside the urban boundary.

While a move to a greenfield site could allow for the construction of new facilities specifically tailored to our service requirements, it had a number of downsides including:

- No land was identified which could realistically contain a facility, of the necessary size, for forensic mental health and intellectual disability patients.
- If a site was able to be identified, the new campus would take between 7-10 years to be completed. Given the rate of deterioration of our buildings, as well as the anticipated demand growth in the short to mid-term, this timeline was deemed suboptimal.
- Relocation was estimated to be more expensive than a redevelopment solution, irrespective of whether the facility was within or beyond the urban boundary.
- Moving to a new site would risk causing material inconvenience to the 400 staff currently working at the Mason Clinic, as well as limiting the ability for patients' families to be able to visit.

¹⁰ Auckland Regional Forensic Psychiatry Services (2012), The Mason Approach: The mission, vision, values and approach of the Mason Clinic.

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- There are inherent risks associated with a relocation process, such as land consent delays and potential resistance from neighbouring residents.

As described above, in March 2018 Cabinet noted that MBIE would seek to agree a transfer of 2.8ha of adjacent land to the Mason Clinic to allow for its expansion. The land transfer was finalised in 2019.

As a result, the relocation option has now been firmly rejected. The acquisition of land adjacent to the existing campus allows us to focus future thinking on the current (and now expanded) Mason Clinic site.

Site master planning

The current site master plan was developed in 2019 by Medical Architecture Australasia Pacific Pty Ltd (MAAP). The master plan aims to realise the best and most efficient use of land, for the benefit of Waitemata DHB and the wider community.

The master plan envisages the demolition of a number of buildings – both inpatient and support facilities – as well as the new construction of a number of inpatient units, utilising the recently acquired land. It incorporates the use of multi-storey inpatient units, which will require the Clinic to transition from its current use of only single-storey units. It includes specialist facilities for forensic intellectual disability patients, high and complex needs patients, and youth forensic patients. The master plan also incorporates an improvement in the quality of the campus environment.

The current master plan was developed after a peer review of the previous master plan (which included two options, with and without additional land). The peer review identified the following issues, which the current master plan addresses:

- There is inadequate space, even with additional land, to fit a campus which only comprises single-storey units. This was partly because there was insufficient space left for garden areas.
- The previous master plan could not realistically be staged, and the master plan required a staging strategy.
- Research into optimising the land for inpatient accommodation was necessary.
- The master plan needed to apply the latest international best practice design principles and precedent studies.
- The location of the secure perimeter and access to common external space and shared facilities needed to be reconsidered.

3.2 The need for investment

There are three key problems with the Mason Clinic's current inpatient facilities:

1. Service capacity is insufficient to meet future demand.
2. Building fabric deficiencies are putting patient and staff safety and service continuity at risk.
3. Facility design does not meet service requirements or support contemporary models of care.

These problems are described below, and the Investment Logic Map (ILM) is included as Appendix A.

Service capacity is insufficient to meet future demand

The Mason Clinic does not currently have the capacity to be able to cater for the forecast future demand for forensic mental health and intellectual disability services. Additional capacity is required for us to continue to provide these services to all patients in the region who require them. Furthermore, if it is

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deemed appropriate that the Mason Clinic should in the future provide additional services for high and complex needs patients or youth forensic services, this will require even more additional capacity.

Current facilities are at capacity

The inpatient facilities are at capacity today. The opening of the unit under construction will provide much-needed additional capacity, but it will be full upon opening with patients transferred from other locations (including the Kahikatea unit, a Wellington facility, and prisons).

As shown in Table 2, of the 121 beds (including the unit under construction), 12 cater for forensic intellectual disability patients (principally in the Pohutukawa unit) and the remainder cater for forensic mental health and adult high and complex needs patients.

Forensic mental health and adult high and complex needs patients share the same facilities, as we use the same model of care to treat them. Once the unit under construction is commissioned, we expect around 20 beds on average will be used by high and complex needs patients, with around 89 used by forensic mental health patients.

Table 2 Current number of inpatient beds, by type

	Number of beds
Forensic mental health & adult high and complex needs	109
<i>Forensic mental health</i>	~89
<i>Adult high and complex needs</i>	~20
Forensic intellectual disability	12
Total	121

The Mason Clinic operates with a waitlist, and there are a number of individuals housed elsewhere who would benefit from its services. In practice, it is the supply of beds that determines where the 'intervention threshold' is set. Therefore, the current level of capacity effectively represents 'demand, at the current policy settings'.

Demand for our current services is growing

The key drivers of demand for forensic mental health and intellectual disability services are overall population, the prison muster, and court case numbers. The majority of the Mason Clinic's referrals are made by prisons and the courts, making prison and court numbers an important consideration, although population growth can helpfully exclude the impact of changes to criminal justice policies.

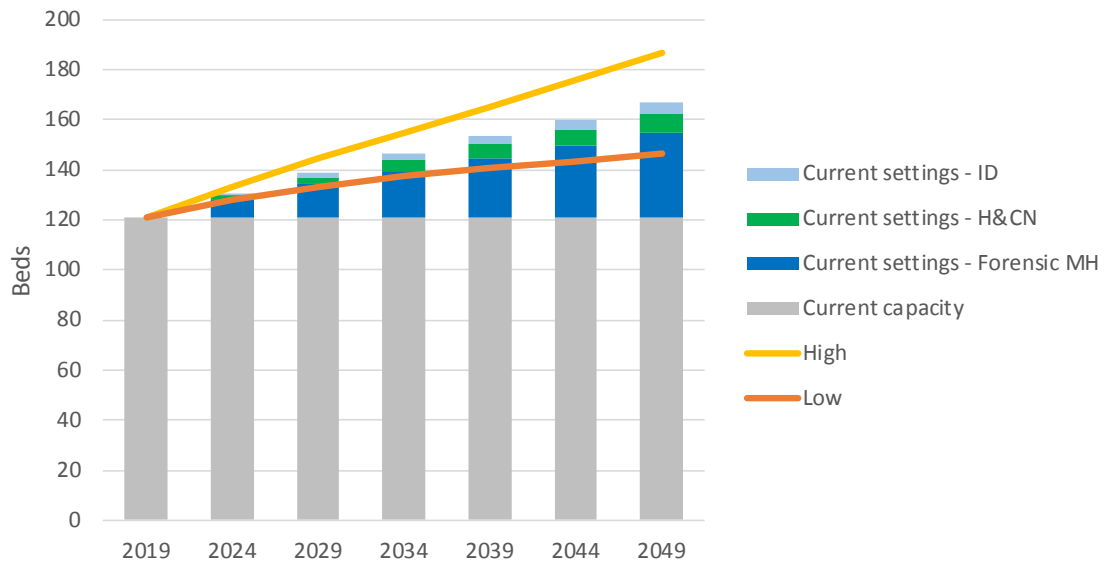
PwC's 2019 analysis of potential growth in bed demand¹¹ noted that, to keep pace with population growth, we would need an additional 46 beds by 2049, to continue to provide services in line with current policy settings. This is shown in Figure 8.

This is a forecast, and therefore the actual number of additional beds that will be required in 2049 is likely to be within a range of this central estimate. PwC's sensitivity analysis suggests that the number of additional beds required by 2049 is likely to be at least 26 beds, and possibly as much as 66. The high and low lines illustrate this in the chart below.

¹¹ PwC: Waitemata DHB – Demand Forecasting for the Mason Clinic (2019)

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Figure 8 Forecast growth in demand for current services



There is demand for specific intellectual disability beds

In addition to an increasing requirement for services generally, demand for dedicated forensic intellectual disability beds is already well in excess of the demand. The Pohutukawa unit is at capacity, and intellectually disabled patients cannot reasonably be accommodated in the other inpatient units. The Pohutukawa unit also only offers one security level.

This means that, when providing additional overall capacity, there is a need to include additional separate specialist facilities for intellectually disabled patients.

Furthermore, there is now a demand for step-down beds specifically for intellectually disabled patients, in order to make it easier to rehabilitate and safely discharge patients into community facilities. The Northern Region does not currently have any such beds, and our intellectual disability patients who would benefit from a step-down bed are currently retained in the Pohutukawa unit. This can be problematic as rehabilitation and longer-stay patients are co-located. The Ministry of Health signalled its desire to explore this development with Waitemata DHB during 2018.

It may be deemed appropriate that we provide additional and/or enhanced services

We are not currently catering for all forensic intellectual disability patients and adult high and complex needs patients who could benefit from the services provided at the Mason Clinic. We also do not have a youth forensic service, although we sometimes house such patients.

Adult high and complex needs

The Mason Clinic is the sole provider of mental health services in the Northern region for non-forensic patients who require a minimum secure environment. Patient numbers fluctuate throughout the year as these patients share the same facilities as forensic mental health patients.

There is a limited understanding of the true demand of this service, although previous reports have attempted to identify the demand in the Northern region. Based on the most recent such analysis (in 2014), it is estimated that 46 beds are needed for adult high and complex patients at the Mason Clinic.

Forensic intellectual disability service

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A demand forecasting exercise undertaken by Synergia in 2015 found that between 0.5% and 1.5% of prisoners have a clinical intellectual disability diagnosis, according to international research.¹² Assuming a 1.0% value, that currently equates to around 37 people in the Northern Region, meaning that the Mason Clinic has a shortfall of around 25 beds for forensic intellectual disability patients. As set out in the PwC report, the Ministry of Health has also estimated current need based on multiple approaches, which produce a range of estimates, both above and below the 37 value we adopt for this business case.

We now provide specific models of care to different types of patient, rather than a more general model of care. However our facilities do not fully allow this.

Youth forensic service

Young people with forensic mental health issues have different needs from adults, and should be treated separately. Facilities built on the Mason Clinic campus were not designed to meet the needs of young people, and there is no fit-for-purpose facility for delivering care to that population within the Northern Region. As a result, children and young people with forensic mental health needs currently have to be transferred to other regions in the country (such as the National Youth Forensic facility in Wellington), displaced from whanau and family support units, against recommended models of care.

Recent discussions with the Ministry of Health (based on analysis originally undertaken in 2011) has determined that around 8 beds are required for Northern Region patients. We estimate that the Oranga Tamariki Legislation Act 2017 has effectively doubled this demand, meaning around 16 beds are currently required.

Table 3 shows the additional beds we would need today in order to provide additional and enhanced services, to accommodate all patients in the Northern Region who would benefit from this service. It also shows how this bed requirement will grow by 2049.

Table 3 Additional beds needed to accommodate additional and enhanced services today

	Number of beds	
	today	by 2049
Adult high and complex needs – enhanced	26	36
Forensic intellectual disability – enhanced	25	34
Youth forensic services – additional	16	22
Total	67	92

Overall bed demand forecasts

As shown in Table 4 and Table 5, by 2049:

- The continued provision of our current services, in line with current policy settings, would require 46 additional inpatient beds, on top of the existing 121 beds, for a total of 167 beds.
- Enhancing the service for adult high and complex needs patients would require up to 36 additional beds.
- Enhancing the service for forensic intellectual disability would require up to 34 additional beds.

¹² Citing, in particular: Fazel S, Xenitidis K, Powell J. (2008). The prevalence of intellectual disabilities among 12000 prisoners - A systematic review. *International Journal of Law and Psychiatry*, 31, 369-373. doi:10.1002/sdr.1525

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- Adding a youth forensic service, which caters for all demand in the Northern Region, would require up to 22 additional beds.
- Providing all the additional and enhanced services noted above would require up to 138 additional beds, bringing the total bed requirement for the Mason Clinic to 259 beds.

Table 4 Forecast bed demand, for all services

Total beds	2019	2024	2029	2034	2039	2044	2049
Current policy settings	121	131	139	146	153	160	167
Additional and enhanced services	188	203	216	228	238	249	259

Table 5 Forecast additional bed requirement, for all services

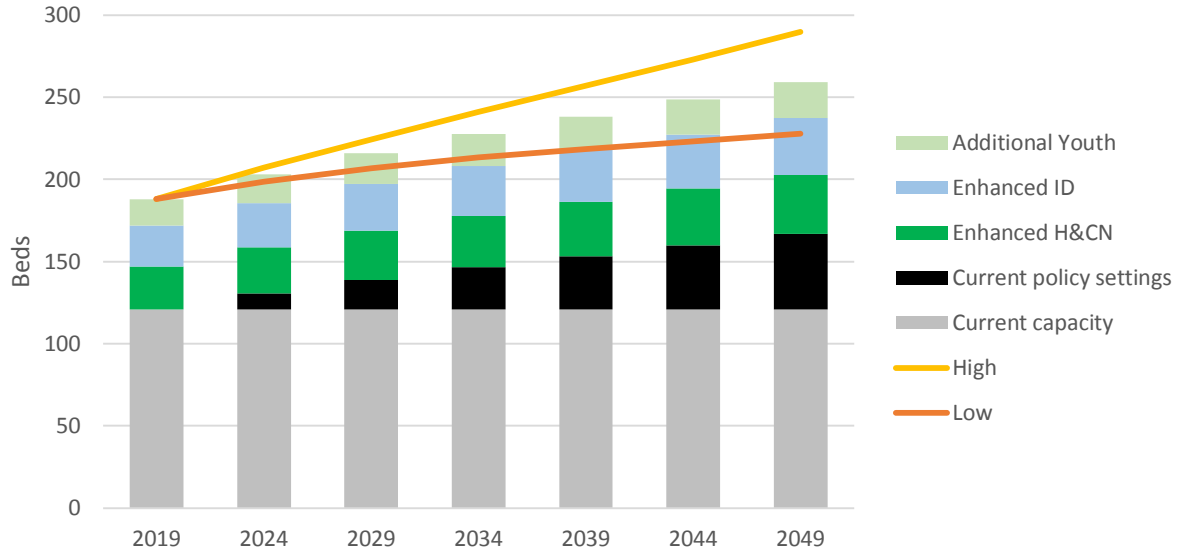
Additional beds	2019	2024	2029	2034	2039	2044	2049
Current policy settings	0	10	18	25	32	39	46
+ Enhanced adult high and complex needs	26	28	30	31	33	34	36
+ Enhanced forensic intellectual disability	25	27	29	30	32	33	34
+ Additional youth forensic	16	17	18	19	20	21	22
TOTAL additional beds	67	82	95	107	117	128	138

This is a forecast, and therefore the actual number of additional beds that will be required in 2049 is likely to be within a range of this central estimate. Sensitivity analysis suggests that the number of additional beds required by 2049 is likely to be at least 107 beds, and possibly as much as 169.

Figure 9 shows that the demand for additional beds to continue to provide services at current policy settings are required progressively over time, while the demand for additional and enhanced services exists today and will also grow over time. The chart also shows high and low sensitivities, based on high and low population projections

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Figure 9 Forecast bed demand, for different policy settings



Not meeting growth is not an option

It is essential that the campus expands to accommodate the forecast growth in service demand. There is no alternative facility in the region to provide forensic mental health services. Inadequate capacity results in offenders with mental health issues being held in prison, which is suboptimal in terms of patient care.

Buildings fabric deficiencies are putting patient and staff safety and service continuity at risk

Four buildings at the Mason Clinic are failing significantly, suffering from weathertightness and leaky building issues – Kahikatea, Rata, Kauri and Totara. These buildings need to be decommissioned as soon as possible, to eliminate significant risks to patient and staff safety.

Weathertightness issues

The Mason Clinic buildings are of mixed material construction, comprising stucco plaster, fibre cement weatherboard and sheet panels, plywood, corrugated iron and concrete block.

Water ingress has been, and is, causing internal damage and compromising the integrity of the buildings. This is partly due to a lack of flashings, damaged roof sheets, window penetrations, and cracks to fibre cement panels.

While this has been mitigated by ongoing repairs, these units have deteriorated to the point where they are at risk of developing *Stachybotrys* fungus in some wall cavities. *Stachybotrys* is a highly dangerous fungus with the potential to cause serious health problems.¹³

Table 6 illustrates the severity of the building fabric issues across the campus. It shows the condition ratings we have given the buildings for the purposes of our Asset Management Plan. The majority have ratings between four and five (out of five).

Table 6 Condition ratings of Mason Clinic buildings

Building	Condition Grade Index	Condition Grade Composition
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¹³ *Stachybotrys* is a toxic mould that can grow in houses and is extremely dangerous to humans. It can cause respiratory problems, skin inflammation, haemorrhage, damage to internal organs, mental impairment, irritation of mucous membranes, tiredness, nausea and immune system suppression.

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		Very good	Good	Moderate	Poor	Very poor
Kauri Totara	4.63	0%	2%	2%	28%	68%
Kahikatea external	4.21	0%	9%	12%	28%	51%
Rata	4.02	0%	11%	15%	35%	39%
Rimu	3.99	0%	15%	6%	44%	35%
Tane Whakapiripiri	4.37	0%	5%	12%	24%	59%
Pohutukawa	4.51	0%	6%	5%	21%	68%
Kowhai	4.27	0%	10%	9%	25%	56%
Puriri	4.43	0%	6%	10%	19%	65%
Te Miro	4.39	0%	8%	2%	33%	57%
Generator house	4.00	0%	13%	13%	35%	39%
Swimming pool building	4.11	0%	10%	9%	41%	40%
Garage	4.15	0%	5%	13%	44%	38%
Parking	3.41	0%	32%	20%	23%	25%

Impacts on patient & staff safety

These issues pose risks to patients and staff. For example, prolonged exposure to the damp conditions and resulting mould spores can cause respiratory illnesses. The risk to patient and staff safety is considered significant and will increase as the buildings continue to deteriorate.

Three monthly testing continues. Recent tests confirmed that the presence of the fungus is currently at safe levels. However, this situation may not continue as the buildings are not weathertight, and higher readings could require immediate decanting of one or more of the units. This creates an unacceptable risk to the health of patients, their families and staff.

The issues with the Tanekaha unit were sufficiently urgent that a business case for replacement was submitted to CIC in 2016. The unit was decommissioned in 2017, and demolished in 2019, as the health risks were deemed too great to continue its use.

Threat of ongoing service provision

The weathertightness issues could render the buildings unfit for use in the near future. Without remediation, it is expected these buildings may have to close in the medium term as the associated health risks from toxic mould spores to patients and staff will be too high. This was the case with Tanekaha.

There is also genuine concern that one of the buildings will suffer catastrophic failure with a severe leak that cannot be contained. If this were the case, there are few options on the site to accommodate patients that would need to be evacuated from the building. Available space would only be found by transforming office or social spaces such as gyms into sleeping areas.

The Mason Clinic's Emergency Response Plan¹⁴ sets out the process for what would happen in the event that one of the clinical units was unfit for use and patients had to be transferred off-site. Patients requiring high security levels would be returned to prison. Lower security patients would be transferred to other inpatient mental health facilities across the region, firstly within Waitemata DHB and then in facilities of the other DHBs. Auckland metro police station cells could also be used, but only for short time periods. This plan is simply not feasible over the medium to long term.

There is no alternative facility which provides forensic mental health services in the region. As such, the potential closure of units at the Mason Clinic puts at risk the ability to provide forensic mental health services to all patients in the region on a sustainable basis.

¹⁴ Waitemata DHB; Regional Forensic Psychiatry Services (September 2015), Mason Clinic: Multi Agency Emergency Response Plan.

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Waitemata DHB considers the risk that a building could become unfit for use is too great for services to continue to be provided without any resolution of this problem. The buildings require major refurbishment and remedial works to make them fit for purpose and eliminate risk to patient and staff health and safety.

Remedial works are required

MaynardMarks carried out an analysis on the Mason Clinic to determine what life remains in the buildings, should no maintenance / remediation is done to the buildings. It was determined that undertaking nothing is not a feasible option.

MaynardMarks determined the current reactive nature of addressing issues as they are identified is in itself a high risk process, as it does not proactively anticipate or mitigate against failures occurring. To date the Mason Clinic has been fortunate that none of the failures or deterioration of the buildings have caused serious health problems for the users of the buildings.

Waitemata DHB therefore considers that the risk that a building could become unfit for use is too great for services to continue to be provided without any resolution of this problem. These buildings need to be decommissioned as soon as possible, to eliminate significant risks to patient and staff safety.

Facility design does not meet service requirements or support contemporary models of care

Most of the Mason Clinic facilities were designed to support a different model of care to that which we operate today. This is limiting our ability to safely and adequately provide forensic health services in line with best practice and our model of care.

The development of contemporary models of care for forensic mental health and intellectual disability services is changing the way those with mental needs or intellectual disabilities in the criminal justice system are assessed, treated and rehabilitated. This model of care requires different facilities to those we currently have – with a greater focus on rehabilitation and reintegration without the use of restrictive interventions, and where services are integrated across the care continuum of security needs.

The introduction of contemporary models of care is changing the Mason Clinic inpatient population. More patients are able to be treated at the Mason Clinic, when they would previously have been held in prison. Furthermore, patients are reintegrated into community facilities earlier than they would previously have been. This means that the Mason Clinic's inpatient population today has, on average, higher acuity and/or security requirements.

The new Te Aka unit is allowing us to provide better care to the patients in that unit, as will the unit currently under construction. With the exception of those two units, the design and configuration of the existing facilities no longer meet the needs of patients. The key problems are as follows:

i. Not enough rooms for assessment, treatment and rehabilitation

Rehabilitation space is important for those with mental health issues to restore independence and promote activities of daily living for when patients can be discharged or supported back into the community. The absence of these facilities can impact patient outcomes of care, delaying reintegration to the community and prolonging length of stay.

Under our contemporary model of care, each unit should have a therapy room, interview rooms, medicine dispensary, lounge area, dining area, sensory modulation capability, access to occupational therapy space, and a family/whanau meeting room. Minimum secure units should have relatively more therapy spaces than other units. Dedicated treatment and assessment rooms are preferable so that patients can receive consultations or medical care in private.

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Not all of the current units have each of these of these areas. Some minimum secure units have a very limited amount of therapy space. In most cases, there are no dedicated areas for therapy groups like sensory modulation.

ii. Communal ablution blocks adversely impact patient experience, and increase staffing requirements

The Australasian Health Facility Guidelines (AHFG) recommend that all beds have access to an ensuite bathroom and shower¹⁵.

Apart from Te Aka and the unit under construction, the other Mason Clinic facilities all have communal bathroom facilities.

This increases the risk of cross-contamination or infection outbreak. It has a negative impact on patient experiences and satisfaction, affecting their overall experience of care due to a loss of privacy and dignity. It increases the staffing requirements within units. It will also make it difficult to phase out the use of night safety procedures, which the Ministry of Health has indicated must occur before 2022.

iii. Rooms are not big enough to adequately cater for long term residents, adversely impacting recovery and clinical outcomes

Many rooms within inpatient units are simply too small to promote the recovery and rehabilitation of patients who may spend years living inside these units. Many also have little natural light.

Insufficient space and light inhibits patient recovery, which can extend their length of stay and lead to poorer rehabilitative outcomes.

iv. Some minimum secure units have seclusion areas, but these are not needed in those units

Seclusion areas were provided in all units under the previous model of care. As a result, a number of our minimum secure units have these rooms.

However, seclusion areas are no longer required for this level of patient risk. They do not promote integration, and are not used under our contemporary model of care.

At present, these spaces are unused and wasted. In addition, their existence in these units does not facilitate a positive rehabilitative environment.

v. No unit has a sufficient security level to provide safe provision of care for high risk patients

A need has been identified for a high secure unit for those who pose greatest risk to the community, staff, other patients and themselves. Since the closure of Wai-o-hine at Lake Alice Hospital, no such facility exists and these patients are either held in prison or accommodated in high care areas of medium secure units.

With modern audio-visual and communications technology, such a facility would avoid the need for unnecessary patient transfers (including for court appearances), which are the point of greatest security and safety risk. It would also allow patients with complex mental health problems to be treated within a healthcare environment, rather than held in prison.

vi. Units that provide related services are not clustered together

¹⁵ Australasian Health Facility Guidelines: Part B – Health Facility Briefing and Planning HPU 131 Mental Health – Overarching Guideline (March 2018)

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Our analysis of patient pathways has indicated that it would be optimal if the units were grouped in to ‘clusters’ of related units – acute and justice liaison, general rehabilitation, Kaupapa Maori rehabilitation, and intellectual disability.

While physical linking has not yet occurred, the clinical operation of clinical clusters has already improved the efficiency of patients’ pathways. There is now a better opportunity to support the use of specialised staff in each cluster.

vii. Rehabilitation units are not grouped into ‘streams’

Rehabilitation units would best be grouped into a three-unit stream with one medium secure, one minimum secure and one with open step down beds. In addition, ideally the medium and minimum secure units would be operationally connected.

The use of streams in this way would better facilitate patient flow between units on the campus. It would also promote efficient clinical care by staff, enhance staff and patient safety, and make it easier for the same staff to provide care for patients across the care continuum of security needs.

Clinical units have already been paired from an operation perspective, but they are not yet physically linked. At the moment, it can be difficult to ensure that the same clinical team cares for each patient throughout the different stages of their inpatient care.

viii. Buildings are not sited around the periphery of the campus

Buildings are currently dispersed across the campus, with some space in between each one. There are two main benefits from siting the units around the periphery of the campus instead.

Firstly, this would provide a shared secure community zone in the middle of campus. This would be a more efficient use of shared space, and better promote integration and rehabilitation for patients. This therefore better supports our contemporary model of care.

Secondly, it would provide a visual and physical barrier to the community. With the potential future redevelopment of Unitec’s land, including the potential for medium density residential housing in areas adjacent to the Mason Clinic, such a barrier would make it easier to balance the needs of the different parties.

3.3 Objectives of the programme

The programme has three investment objectives, linked to its three problems, as set out in Table 7.

The urgency of this programme is driven by two factors:

- The lack of any capacity to cater for future demand growth and/or the provision of additional and enhanced services (Problem 1).
- The building fabric deficiencies at four inpatient units which have created an unacceptable risk to patients, their families, and staff (Problem 2).

But while addressing the above issues is critical, any solution also needs to improve the ability of the facilities to support contemporary models of care (Problem 3).

Table 7 Investment objectives

Objectives	Description
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Additional capacity, sufficient to cater for demand growth and (if required) additional and enhanced services	<ul style="list-style-type: none"> • Sufficient capacity to cater for increasing future demand for 30 years, for current services in line with current policy settings. • Sufficient capacity to provide additional and/or enhanced services, if that is requested by the Ministry of Health.
Weathertight buildings	<ul style="list-style-type: none"> • Facilities which are weathertight, and which do not pose a health and safety risk to patients and staff.
Fit-for-purpose facility design and configuration	<ul style="list-style-type: none"> • Facilities which are designed to support contemporary models of care, to ensure good patient outcomes, patient experience and productivity. • Dedicated facilities for Intellectually disabled patients, adult high and complex needs patients, and youth forensic patients.

3.4 The benefits of investment

Addressing the issues identified above will provide a number of benefits to patients.

Sustainable provision of services

Additional capacity will enable the Mason Clinic to continue to cater for all patients who require our services. Without an expansion of capacity, we would need to move patients to other sites, and will need to waitlist an increasing number of prisoners who would benefit from hospital admission.

The addition of new capacity in specific areas – e.g. maximum security, units to cater for patients with high and complex needs, intellectual disabilities or youth (as deemed appropriate) – will ensure that those patients will continue to receive the specific support they need, in line with contemporary models of care.

Addressing weathertightness issues with the existing facilities will remove the risk that those units will need to close in the near term. This will ensure that the physical units will be able to continue to provide services into the future.

Support for contemporary models of care

The provision of facilities which focus on rehabilitation and reintegration will enable us to fully implement our contemporary model of care. Furthermore, the re-configuration of facilities into clusters of complementary services will facilitate patient flow, provide better continuity of care, and improve staff and patient safety, in line with contemporary best practice.

Facilities which incorporate some flexibility to make changes to room usage, security levels and similar will help ensure that they can remain fit for purpose into the future.

Better patient outcomes

Facilities designed for today's forensic mental health population and models of care will enable Waitemata DHB to provide higher quality and more effective care for its patients.

With modern facilities our patients will receive assessment, treatment and rehabilitation which is aligned to contemporary best practice. Waitemata DHB will have the ability to respond to changing patient needs and provide them within a positive environment for rehabilitative services that supports improved health outcomes.

The provision of dedicated facilities for high and complex needs patients and youth forensic patients (if deemed appropriate) will ensure that they receive appropriate care in a unit specifically designed for their needs.

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Improved patient and staff experience

The addition of dedicated rooms for rehabilitation and therapy, whanau meetings and spaces for recovery and rehabilitation will improve patient experience.

Improved building layouts, including non-communal ablution blocks, greater natural light, larger rooms, and secure conditions more suitable for each type of patient, will improve patient experience, both in terms of therapy and living conditions.

Purpose built buildings, in line with contemporary models of care are also likely to improve staff satisfaction, reducing the need for unnecessary transfers of care, promote efficient delivery of care and provide a more clinically safe environment in which to work.

The provision of dedicated facilities for high and complex needs patients and youth forensic patients (if deemed appropriate) will improve patients' experience, ensuring that they receive care which is appropriate for them in a suitable environment.

Addressing weathertightness issues will provide a safer environment for both staff and patients, as there is less risk being exposed to the damp conditions and associated mould spores.

3.5 Strategic alignment

Northern Region LTIP

The redevelopment of the Mason Clinic, including the provision of additional capacity, is included in the NRLTIP as a key investment. The NRLTIP states that:

“The Mason Clinic will be expanded to meet future forensic mental health demand and may grow to include minimum secure services.” (page 109)

It is a key response to “Problem #3” of the NRLTIP – demand growth. The programme is providing additional capacity for the benefit of the whole region.

It provides a partial response to “Problem #2” – patient centricity and outcomes.

The other Northern Region DHBs are all supportive of this redevelopment programme, to ensure that the region can continue to provide forensic mental health services in the future.

National strategies and direction

Living Standards Framework

The Government and Treasury have developed a Living Standards Framework to consider the effects of policy choices on New Zealanders' living standards. This aligns the stewardship of the public finance system with an intergenerational wellbeing approach.

The programme contributes to improving the living standards of New Zealanders by improving the 'health' and 'human capital' elements of the Living Standards Framework. In turn, improved health outcomes contribute to the 'jobs and earnings', 'income and consumption' and 'social connections' elements, among others.

The provision of sufficient capacity to enable us to continue to meet demand and potentially to provide additional and/or enhanced services, in fit-for-purpose facilities supporting contemporary models of care and which are weathertight, will all improve overall patient outcomes and wellbeing.

Ministry of Health Statement of Strategic Intentions

The Ministry of Health 2017-21 Statement of Strategic Intentions (SOSI) sets out the Government's high-level objectives and priorities for the health system. Its strategic framework is focussed on New

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Zealanders living longer, healthier and more independent lives. It describes service provision which incorporates the different health circumstances of different groups and how this is changing, as well as improved access to services, and services being provided closer to home where possible.

This programme will help contribute to the aims of the Government by expanding capacity to meet rising demand ensuring that the ARFPS can continue to provide the same level of access and high quality patient care, as well as enabling the safe delivery of contemporary models of care. The provision of fit for purpose facilities, focused on rehabilitation and reintegration, will support better outcomes for patients.

New Zealand Health Strategy

The 2016 New Zealand Health Strategy (the Strategy) sets the framework for the New Zealand health system to address the pressures and demands on its services, and the direction for development for the next ten years.

The Strategy sets the framework for the health system to address the significant demands for its services within a constrained fiscal environment. It calls for an integrated approach to care and a focus on tailoring services to those groups who have poorer health and social outcomes than the population on average, specifically people with disabilities and people with mental health conditions, such as those the Mason Clinic provides services for.

This programme seeks to redevelop facilities at the Mason Clinic so that they better enable contemporary models of care, enhance continuity of care across the care continuum, and promote multidisciplinary working. It also aims to improve efficiency and maximise the benefit from fiscal contributions.

This calls for an integrated approach to care and a focus on tailoring services to those groups who have poorer health and social outcomes than the population on average, specifically people with disabilities and people with mental health conditions.

The Mason Clinic redevelopment programme supports the strategic direction of Government by providing safe facilities in which to provide necessary mental health services to offenders. Redesigned facilities and co-located services, outlined in this strategic case, are in line with the Government strategic priority to provide quality integrated mental health services for all New Zealanders.

Ministry of Health Letter of Expectations for DHBs

The Minister of Health's 2019/20 letter of expectations sets out the Minister's high-level expectations for DHBs. 'Mental health and addiction care' is set out as a priority area for the Government, and an expectation is stated that DHBs prioritise strengthening and improving mental health services.

This programme will help contribute to the Government's priority area of mental health by enabling the safe delivery of contemporary models of care and expanding capacity to ensure patients receive the proper treatment they need.

The letter of expectations also contains a number of items which this programme is aligned with. Most notably:

- We will support the ongoing development of the National Asset Management Plan, and envisage integrating the outcomes of that work with our subsequent business case processes.
- As part of the procurement of the programme, we will endeavour to develop construction skills and training as much as feasible.

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Waitemata DHB Strategic Priorities

This programme is well aligned to the DHB’s values and priorities set out in the Health Services Plan.¹⁶ As described above, the current facilities deliver suboptimal patient care and experience, and redeveloping them will help us achieve our two key priorities of enhancing patient experience and achieving better outcomes.

As set out in Table 6, this programme also supports the DHB’s strategic themes, which the Board has determined that all projects and initiatives will align with.

Table 8 Alignment with Waitemata DHB Strategic Themes

Strategic theme	Alignment of Mason Clinic Redevelopment
Community, whanau and patient centred model of care	One of the key drivers of the programme is to enable Waitemata DHB to support its desired model of care with facilities that enable this.
Emphasis and investment on both treatment and keeping people healthy	Redeveloping the Mason Clinic will assist Waitemata DHB to maintain timely access to forensic mental health services for all patients that need them. Redeveloped facilities will ensure that Waitemata DHB meets increasing demand, without reducing access, and maintains or improves the clinical outcomes of its patients.
Service integration and/or consolidation	Expanding capacity will ensure that all core forensic services can continue to be provided from the Mason Clinic site. In addition, the programme incorporates an option to co-locate related services with core forensic services. A new configuration of buildings on the campus could facilitate better integration between units, and provide better continuity of care and staffing efficiency.
Intelligence and insight	The redevelopment will allow Waitemata DHB to make the best use of new technology, intelligent ways of working along with updated models of care for forensic mental health and intellectual disability patients.
Evidence informed decision making and practice	This PBC provides initial programme-level thinking about a preferred way forward. The proposed programme of works was determined based on criteria informed by evidence and current best practice.
Outward focus and flexible, service orientation	New fit-for-purpose facilities will enable Waitemata DHB to better deliver contemporary model of care, and allow it to improve the patient experience. Increased flexibility in the design of the environment will enable patient-centric model of care improvements, which is not possible with the current arrangement.
Operational and financial sustainability	An expansion of capacity at the Mason Clinic will ensure capacity for future demand growth. The redevelopment of existing facilities, and the potential co-location with related services, have a number of potential efficiency benefits.

¹⁶ Waitemata DHB, Health Services Plan 2015-2025

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Campus master planning

The programme of works described in this PBC is fully consistent with the latest master planning for the Mason Clinic. The master planning process has been an integrated part of the development of the PBC, and will continue to heavily inform subsequent business cases for the programme.

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4. Economic Case

The purpose of the economic case is to explore the available options and identify a preferred way forward which represents the best value for money.

4.1 Evaluation approach

Critical success factors

The items set out in Table 9 are critical to the success of the programme.

Table 9 Critical success factors for the Mason Clinic redevelopment programme

Critical success factors	Description
Strategic fit and business need	<ul style="list-style-type: none"> Meets the investment objectives of the programme Is well aligned with our site master planning
Potential value for money	<ul style="list-style-type: none"> Is preferable to a 'do nothing' option, in terms of meeting the objectives of the programme
Potential affordability	<ul style="list-style-type: none"> Can be met through likely available funding sources
Potential achievability	<ul style="list-style-type: none"> Can be delivered by Waitemata DHB in the timeframe required, given the capability requirements to manage delivery

Overview of evaluation process

A range potential approaches to addressing the problems identified at the Mason Clinic have been considered, across three dimensions:

- **Programme-level options** – Redevelopment, refurbishment or relocation.
- **The services and policy settings** – Current policy settings and/or additional and enhanced services
- **Inpatient building typology** – Single-storey vs multi-storey units.
- **Staging** – Staging of the different elements of the programme.

In each case, the merits of alternative options have been assessed with reference to the investment objectives and critical success factors set out above.

4.2 Options analysis

To determine the preferred programme, we considered a range of options.

Programme-level options

Three high-level approaches to addressing the problems identified with the Mason Clinic facilities were evaluated:

The preferred approach of facility replacement and redevelopment on the current site was considered against two other high-level options:

- Relocating the Mason Clinic service to an alternative location.

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- Replacement of existing facilities, and redevelopment on the current site.
- Refurbishment of existing facilities, and the addition of capacity on the newly acquired land.

1. Relocation

As described in more detail in Section 3.1, the potential option of relocating the Mason Clinic service elsewhere has been considered in depth by Waitemata DHB and central agencies in recent years, and has been rejected for a number of reasons.

The recent acquisition of land adjacent to the existing campus allows us to focus future thinking on the current (and now expanded) Mason Clinic site.

2. Replacement and redevelopment on current site

This option involves the demolition of the four units which are failing (Kahikatea, Rata, Kauri and Totara), and the construction of new inpatient units on the land currently occupied by the failing units and the newly acquired land.

Table 10 sets out the extent to which this approach can achieve the investment objectives and critical success factors.

Table 10 Assessment of replacement and redevelopment

Objectives / critical success factors	Assessment
Additional capacity	<ul style="list-style-type: none"> • Additional capacity can be provided on the newly acquired land. • The replacement of existing units gives us an opportunity to also add capacity on the existing campus footprint.
Weathertight buildings	<ul style="list-style-type: none"> • New units will be designed to ensure that there would be no weathertightness issues.
Fit-for-purpose design and configuration	<ul style="list-style-type: none"> • All new facilities will be fit-for-purpose, supporting contemporary models of care and enabling good patient outcomes. • Dedicated units can be developed for forensic intellectual disability, high and complex needs, and youth forensic patients.
Potential value for money	<ul style="list-style-type: none"> • Cheaper solution than refurbishment or relocation. • Provides a long-term focused solution, which best utilises the newly acquired land.
Potential affordability	<ul style="list-style-type: none"> • Dependent on Crown capital funding availability.
Potential achievability	<ul style="list-style-type: none"> • The redevelopment will take several years to complete. However, the newly acquired land would allow for us to begin in the near term. • Initial construction on the newly acquired land allows for decanting from the failing units.

3. Refurbishment of existing facilities

The gradual deterioration of the premise is result of an inherent weather tightness issue which has previously been treated on an ad-hoc basis. The remedial works based solution, would involve continuing

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to monitor the four main units (Kahikatea, Rata, Kauri and Totara) by way of six monthly tests for fungal growth and subsequently addressing the issues on an ad-hoc basis to prolong the useful lives of these buildings.

Table 11 sets out the extent to which this approach can achieve the investment objectives and critical success factors.

Table 11 Assessment of refurbishment

Objectives / critical success factors	Assessment
Additional capacity	<ul style="list-style-type: none"> Additional capacity can be provided on the newly acquired land. Minimal ability to add capacity on the existing campus footprint. Should the deterioration of the units occur quicker than anticipated, one of the units could be prematurely closed without a temporary substitute.
Weathertight buildings	<ul style="list-style-type: none"> Temporary relief from the symptoms of weathertightness will be provided, but the issue will not be able to be fully addressed. These buildings would continue to carry an inherent risk of becoming a hazard.
Fit-for-purpose design and configuration	<ul style="list-style-type: none"> All new facilities will be fit-for-purpose, supporting contemporary models of care and enabling good patient outcomes. The refurbished units will continue to have poor design and configuration. Our ability to provide dedicated units for forensic intellectual disability, high and complex needs, and youth forensic patients is limited by the footprint constraints of the current inpatient units.
Potential value for money	<ul style="list-style-type: none"> More expensive solution than replacement and redevelopment, without providing any substantial improvements to the status quo.
Potential affordability	<ul style="list-style-type: none"> Dependent on Crown capital funding availability.
Potential achievability	<ul style="list-style-type: none"> The redevelopment will take several years to complete. However, the newly acquired land would allow for us to begin in the near term. Initial construction on the newly acquired land allows for decanting from the units being refurbished.

Conclusion

Replacement and redevelopment is the preferred approach, for the following reasons:

- The cost of maintaining and refurbishing the existing buildings is greater than the cost of replacement.
- Refurbishment would not be able to fully address the weathertightness, and hence these buildings would continue to carry an inherent risk of becoming a hazard.

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- Refurbishment would not allow us to increase capacity on the existing campus footprint (only on the newly acquired land).
- Refurbishment would not allow us to improve the design and configuration of the existing units.
- Relocation has already been rejected as an option.

Services and policy settings

As described above, the Mason Clinic currently provides forensic mental health, adult high and complex needs and forensic intellectual disability services, at a level of service reflecting current policy settings. At a minimum, we need to continue to cater for our current services at current policy settings.

However, as also described above, it is possible that the Mason Clinic may be requested by the Ministry of Health to provide an additional youth forensic service and/or enhanced adult high and complex needs and forensic intellectual disability services. It is currently unclear whether, and if so when, such requests may be made.

The demand forecasts shown in Section 3.2 are based on an assumption that policy discussions will lead to the Mason Clinic being directed to provide all additional and enhanced services within five years. The proposed timing and staging described in this section is consistent with that assumption.

In practice, we will only provide new capacity at the time it is needed. If requests from the Ministry occur later than currently assumed, then the facilities to cater for those additional and enhanced services will be provided later. If such requests are never made, then the relevant facilities will not be constructed. This will mean the overall programme will focus more on core services, and the provision of additional capacity will occur more slowly.

The timing and staging presented below is a scenario, based on an assumption about future policy settings. The practical timing and staging (and the specific facilities themselves) will be driven by actual future policy settings.

New inpatient building typology

The Mason Clinic currently comprises only single-storey inpatient units. We evaluated the continuation of this typology against the use of multi-storey units.

We note that the Ministry of Health has carried out an extensive study on this topic, and our analysis and conclusions below are partly based on the results of that work.

Single-storey units

This building typology involves a single floor of inpatient rooms, although it may have a second floor comprising administrative or support rooms.

Table 12 sets out the extent to which this typology can achieve the investment objectives and critical success factors.

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Table 12 Assessment of single-storey units

Objectives / critical success factors	Assessment
Additional capacity	<ul style="list-style-type: none"> Difficult to provide sufficient capacity, within the Mason Clinic’s constrained footprint, using only single-storey units. (This was a key finding from the peer review of our previous master plan.)
Weathertight buildings	n/a
Fit-for-purpose design and configuration	<ul style="list-style-type: none"> Outdoor centric, and provides easy access to fresh air, sunlight, and basic exercise. Well-aligned to contemporary models of care, focusing on rehabilitation and re-integration. Building set-up is less ‘institutionalised’, and is less custodial and more therapeutic. Occupies more land per bed, inhibiting the use of land for therapeutic uses, which is counterproductive to the model of care. More susceptible to disturbance, and overlooking from adjacent central spaces not associated with the Clinic.
Potential value for money	<ul style="list-style-type: none"> No significant difference in per-bed cost, relative to multi-storey units.
Potential affordability	<ul style="list-style-type: none"> Dependent on Crown capital funding availability.
Potential achievability	<ul style="list-style-type: none"> Difficult to stage. Would require greater staffing levels.

Multi-storey units

This building typology involves two or more floors of inpatient rooms, and potentially additional floors comprising administrative or support rooms.

We are currently only seriously considering the use of two-storey units as part of the redevelopment programme, although our analysis is consistent with higher units as well.

Table 13 sets out the extent to which this typology can achieve the investment objectives and critical success factors.

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Table 13 Assessment of multi-storey units

Objectives / critical success factors	Assessment
Additional capacity	<ul style="list-style-type: none"> Enables greater capacity than single-storey units. This is especially important for the Mason Clinic, given its constrained footprint. Increases options for locating on-campus carparking in the short term.
Weathertight buildings	n/a
Fit-for-purpose design and configuration	<ul style="list-style-type: none"> Residents of upper floors have reduced garden access, with smaller gardens and balconies on those floors. Enables additional space to be used for a central garden area. Enables support spaces to be used more efficiently.
Potential value for money	<ul style="list-style-type: none"> No significant difference in per-bed cost, relative to single-storey units.
Potential affordability	<ul style="list-style-type: none"> Dependent on Crown capital funding availability.
Potential achievability	<ul style="list-style-type: none"> Allows easier decanting and better staging of the programme. Can efficiently utilise the sloping topography of the newly acquired land at the north end of the site. Would require lower staffing levels.

Conclusion

Two-storey units are the preferred building typology for the Mason Clinic, at least for ‘standard’ facilities, for the following reasons:

- It enables a greater maximum bed capacity within the constrained footprint of the site. Unlike some other mental health facilities in New Zealand, land constraints are a critical consideration for the Mason Clinic.
- It allows easier decanting and better staging of the programme, with one new unit able to replace two existing units.
- It utilises the sloping topography of the newly acquired land at the north of the site, with two-storey units in this part of the campus effectively able to provide ground level access from both inpatient floors.
- It enables additional space to be used for a central secure garden area.
- It increases options for locating on-campus carparking in the short term.
- It enables support spaces to be used more efficiently.

We note that multi-storey facilities have operated successfully in a number of international locations, and are able to support contemporary models of care.

The main disadvantage of a multi-storey solution is that residents of upper levels have reduced access to gardens – with smaller gardens and balconies on those floors. However, this can be offset by having a

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larger common central garden, and designing the security levels such that those on the upper floors are also those who have the greatest allowed access to the central secure garden.

We note that some specialist facilities are likely to continue to be single-storey. For example, our master plan currently envisages that any dedicated unit for youth forensic patients, or a step-down unit for intellectually disabled patients, would be single-storey.

Staging

The programme will be completed in stages to ensure that there are no additional capacity constraints due to the temporary closure of buildings. Furthermore, a staged approach allows us to retain flexibility to adjust the programme if necessary.

Initial works

The only feasible option for the first stage of the programme is to build new inpatient units on the newly acquired land at the north end of the site.

- We must continue to provide inpatient services during the redevelopment, and reducing capacity for a period is not a viable option. Hence it is not possible to decommission an existing building before a new one is built. Therefore, the first step in the redevelopment programme must involve constructing a new unit or units.
- There is no space of a sufficient size within the existing 3.9ha campus to construct a new unit. Therefore, the newly acquired land must be used.
- The Northern site is preferred to the South for two reasons:
 - Its natural sloping topography lends itself to the construction and placement of multi-storey inpatient units, being effectively able to provide ground-level access to both inpatient floors.
 - The Southern site is best suited to future rehabilitation units with lower security, due to its proximity to the Mahi Whenua sanctuary garden and a water stream partially running through from the existing site. This waterway divides the campus, and does not work well with the concept of a 'central secure garden' for core forensic services.

There is space for two new inpatient units on the Northern land. Two two-storey units would provide 60 beds, which is the same total capacity as the four failing units. Constructing two new units therefore allows the demolition of the failing units without any loss of capacity.

Staged demolition

The construction of two new units on the Northern land allows for the demolition of the four failing units. There is then the ability to construct two new units (and associated garden space) on the land currently occupied by the failing units.

We have considered three options for staging the initial construction and demolition of units:

1. Replace all the failing units together, and decommission as soon as possible.
2. Only replace two of the failing units initially (replaced with one two-storey unit), and then replace the other two units later.
3. Construct the two new units together, but only decommission two of the four failing units initially, with the other two units remaining in operation for a period of time.

Each of the above three options involves the construction of around 120 beds on the northern and western areas of the campus, and the demolition of 60 beds in the failing units, but the different sequencing has some practical implications.

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Option 1 replaces all four failing units at the same time, before adding capacity. This option involves the least sub-stages, and allows the quickest replacement of the failing units.

Option 2 replaces two units at a time (rather than all four together), before then adding capacity. This option may be preferred if funding constraints limit the initial construction to one unit. However, it has a number of practical disadvantages, which are described in more detail in Section 4.4.

Option 3 adds 30 beds of capacity initially, and then replaces the failing units while maintaining this higher capacity level. This approach is more complex and would require additional staging. It would only be warranted if the additional capacity was needed more urgently than it could be provided under the other options.

The preferred approach at this time is Option 1, given the urgency with which the existing units need to be replaced, and the unit currently under construction is providing additional capacity in the short term. However, this will be reconsidered through the development of the tranche-based business cases.

Addition of capacity

Following the replacement of the four failing units with two new 30-bed units, the remainder of the programme involves adding capacity through the construction of a series of new units.

These will include both 'standard' forensic mental health units, but also specialist units for intellectual disability services (including step-down beds), high and complex needs patients, and (if deemed appropriate) youth forensic services.

It is currently envisaged that these units will not be constructed all at one time, but over a period of time based on regional demand. As such, the addition of capacity is likely to occur through a number of sub-stages.

The specific numbers of each type of unit, their specific location within the campus, and the order in which each unit is built, will be determined during the business case process for Stage 2. This will be based on updated demand forecasts for each service, and any further direction from central agencies regarding the provision of youth forensic services and additional services for high and complex needs patients.

The current master plan envisages the potential addition of 45 forensic mental health beds, 15 high and complex needs beds, 32 intellectual disability beds, 9 step-down beds, and 15 youth forensic beds (116 additional beds in total). This is based on our current understanding of future demand requirements, and it also incorporates the possibility that central agencies may deem it appropriate for the Mason Clinic to increase its level of service for these dedicated services in the future. However the actual numbers will be determined during future business case processes.

A possible sequencing of construction of inpatient units is as follows. This will also be refined and confirmed during the future business case processes.

1. A 30-bed forensic mental health and adult high and complex needs facility, on the western side of the campus.
2. A 20-bed forensic intellectual disability unit, next to the existing Pohutukawa unit.
3. A 15-bed youth facility, on newly acquired land at the southern end of the site.
4. A 9-bed step-down unit for forensic mental health patients, next to the existing Rimu unit.
5. A 30-bed forensic mental health unit, on the western side of the campus (potentially developed in two stages).
6. An 12-bed intellectual disability unit, on the western side of the campus.

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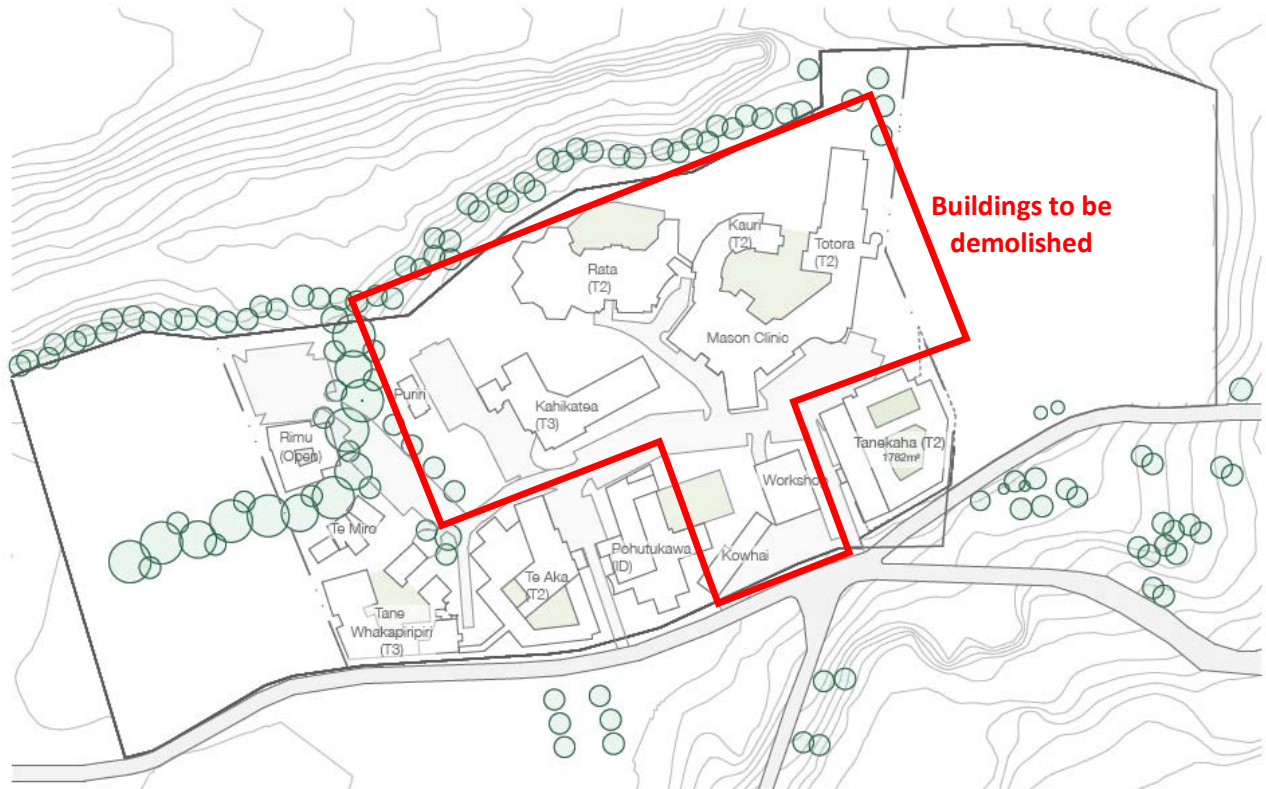
4.3 Proposed programme of works

Below we set out our proposed redevelopment programme, following the analysis of alternative options outlined above.

Overview

Figure 10 shows a map of the Mason Clinic at present, including the unit currently under construction.

Figure 10 Mason Clinic at present (including unit under construction)



Our proposed redevelopment of the Mason Clinic involves:

- The construction of a number of modern single and multi-storey units, over the land under the units to be demolished and the newly acquired land, to provide capacity for up to 246 beds.
- Demolition of the existing units with serious weathertightness issues and which are no longer fit for purpose – Kahikatea, Rata, Kauri and Totara – and some aging support buildings such as Kowhai and the workshop.
- Retention, and potential upgrade, of the other existing inpatient units and buildings.
- The construction of a series of shared support facilities to accommodate front-of-house and security, judicial, therapeutic, wellness, administrative and non-clinical support functions.
- Provision of additional on-site carparking for staff and visitors, together with access for emergency and support traffic.
- An increase in total building footprint from 30% of the site to 34%, while at the same time almost doubling the inpatient capacity.
- The use of three main stages of work, each of which may have sub-stages, with redevelopment beginning from the Northern end of the campus.

Mason Clinic Programme Business Case – Economic Case

Stage 1

The first stage will involve replacing the buildings with weathertightness issues with new facilities, with no change in overall capacity.

- Two new two-storey units will be built on the newly acquired land at the north end of the site. Each unit will have 30 beds, 15 on each level (60 beds in total), and will be a combination of minimum (T3), medium (T2) and high (T1) security levels.
- The Kahikatea, Rata, Kauri and Totara units will be decommissioned, along with the Puriri, Kowhai and workshop support buildings. This will remove 60 beds currently in use.¹⁷
- A three-storey shared activity and support building, including two-storey entry court, front of house, judicial activities, drop-off, access and carparking will be constructed on the newly acquired land, and the start of the central secure garden will be created.

This is a necessary first step before additional capacity can be contemplated.

Figure 11 shows what the Mason Clinic will look like after Stage 1 is complete.

Appendix B contains possible floor plans of the two new units constructed during Stage 1.

Figure 11 Future Mason Clinic after Stage 1



¹⁷ It is assumed that, when the unit under construction is commissioned, the operational capacity of Kahikatea will be reduced from 20 to 15 beds.

Mason Clinic Programme Business Case – Economic Case

Stage 2

The second stage will involve the demolition of the decommissioned units, the provision of urgently needed additional capacity, and the provision of specialist facilities for additional and enhanced services.

- The Kahikatea, Rata, Kauri and Totara units, along with the Puriri, Kowhai and workshop support buildings, will be demolished.
- Two new facilities for forensic mental health patients will be built:
 - A two-storey unit, with 30 beds and administration spaces, similar to those built in Stage 1. It is expected to cater for adult high and complex demand patients, in addition to forensic mental health patients, and be cited on the western side of the campus.
 - A single-storey unit, with nine specialist step-down beds, next to the existing Rimu unit.
- If deemed appropriate, two specialist units will be built to provide to provide additional and enhanced services:
 - A two-storey specialist unit for forensic intellectual disability patients, next to the Pohutukawa unit on the current site of the Kowhai and workshop buildings.
 - A two-storey specialist unit for youth forensic patients, on the newly acquired land at the southern end of the campus.
- The specific numbers of each type of unit, their specific location within the campus, and the order in which each unit is built, will be determined during the business case process for Stage 2. This will be based on updated demand forecasts for each service, and any further direction from central agencies regarding the provision of youth forensic services and additional services for high and complex needs patients.
- These facilities could be constructed all at one time, or they could be staged. At least one of the two forensic mental health units will be needed urgently, but timing for the specialist youth and intellectual disability units will depend on when (and if) they are deemed appropriate. As such, Stage 2 may be delivered in multiple sub-stages.

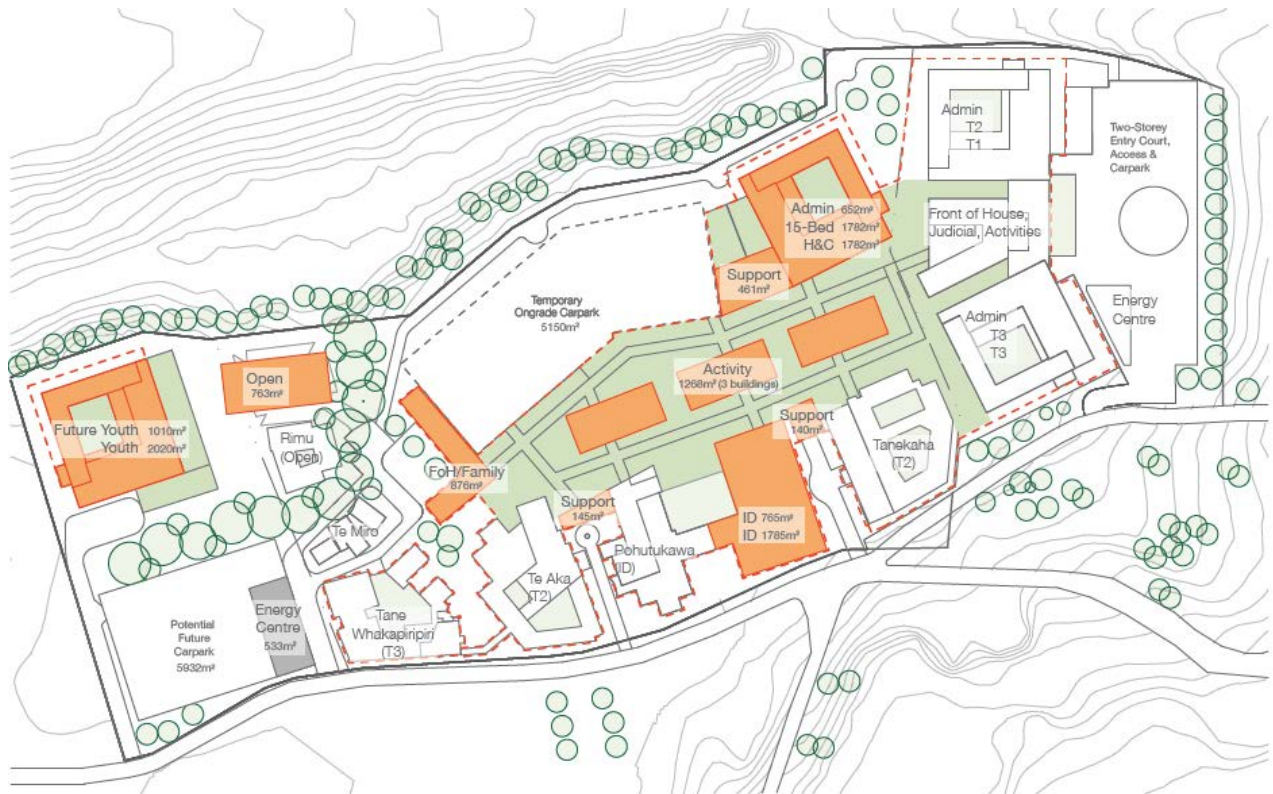
For the purposes of the master plan and this PBC, we have assumed that policy discussions will lead to the Mason Clinic being directed to provide all additional and enhanced services within five years, and as such the provision of units for these services are included with Stage 2 (rather than delayed until Stage 3).

- If all such facilities set out above are constructed, this will involve the addition of 77 beds during this stage, increasing the total capacity of the Mason Clinic from 121 to 198 beds.
- Additional support buildings and carparking will be constructed, along with further development of the central secure garden. This will include the return of community facilities removed during Stage 1.

Figure 12 shows what the Mason Clinic will look like after Stage 2 is complete, based on the current master plan, assuming the development of facilities for additional and enhanced services.

Mason Clinic Programme Business Case – Economic Case

Figure 12 Potential future Mason Clinic after Stage 2



Stage 3

The third stage will involve adding further capacity over time, as required by demand.

- The types of units, the specific numbers of each, their specific location within the campus, and the order in which they are built, will be determined during the business case process for Stage 3. This will be based on updated demand forecasts for each service, the amount of further capacity which is ultimately provided during Stage 2, and any further direction from central agencies regarding the provision of youth forensic services and additional services for high and complex needs patients.
- The current master plan envisages the potential addition of 48 beds during this stage (over and above those added during Stage 2), increasing the total capacity of the Mason Clinic to 246 beds. The master plan envisages these units to comprise:
 - one additional 30-bed unit for forensic mental health patients, on the western side of the campus
 - one 12-bed unit for forensic intellectual disability patients, on the western side of the campus
 - an expansion of the youth unit built in Stage 2. .
- These units are envisaged to be constructed in multiple sub-stages, based on regional demand.
- Additional support buildings and carparking will be constructed, and the central secure garden area will be finished.

Mason Clinic Programme Business Case – Economic Case

Figure 13 shows what the Mason Clinic will look like after Stage 3 is complete, based on the current master plan.

Figure 13 Potential future Mason Clinic after Stage 3



Timing

Table 14 sets out indicative timing for each stage of the redevelopment, based on our current thinking regarding the demand requirements and sequencing.

Table 14 Indicative timing for each stage of development

Redevelopment stage	Indicative completion date
Stage 1	
Construction of new units	2022
Stage 2	
Demolition of four existing units	2023
Forensic mental health and adult thigh and complex needs units	2024
Forensic intellectual disability unit	2024
Youth forensic unit	2027
Forensic mental health step-down unit	2027
Stage 3	
Forensic intellectual disability unit	2039
Forensic mental health unit	2045

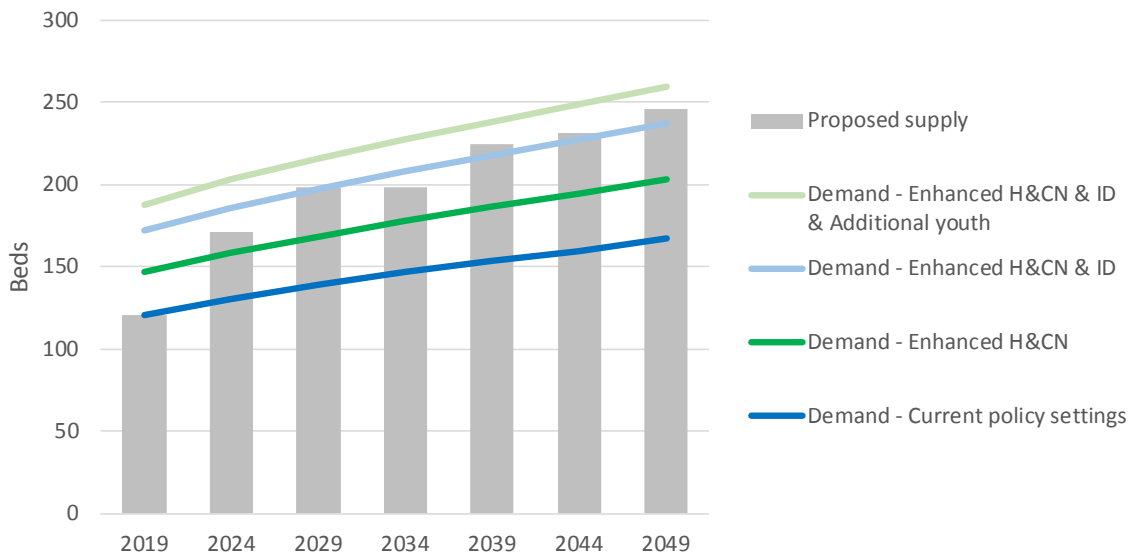
Mason Clinic Programme Business Case – Economic Case

This timing will be reconsidered during the development of each tranche-based business case. Among other things, as discussed below, the timing of the redevelopment will be constrained by capital funding availability.

Response of supply to demand growth

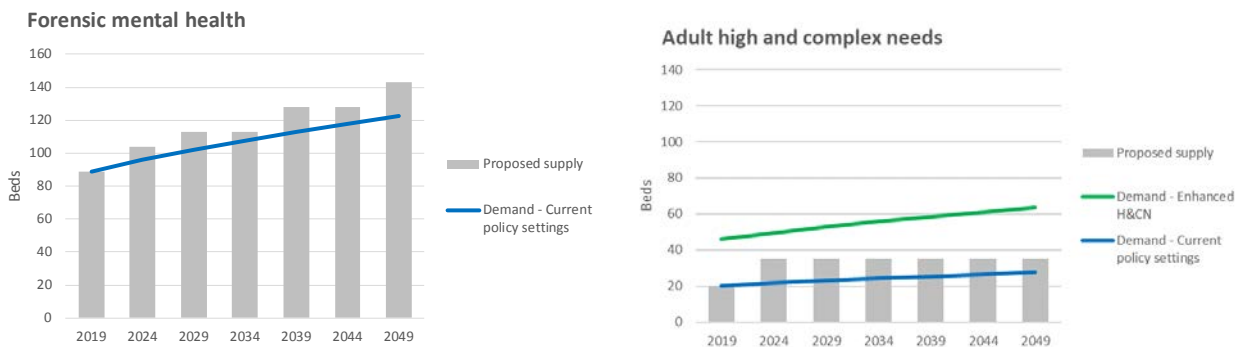
Figure 14 illustrates what the above timing means for the ability of future capacity to meet demand. The chart shows that during the 2020s, as part of Stage 2 of the redevelopment, we will add capacity to both cater for growth in existing services and accommodate additional and enhanced services. We will then add additional capacity over time to keep pace with increasing demand.

Figure 14 Indicative timing of capacity increases

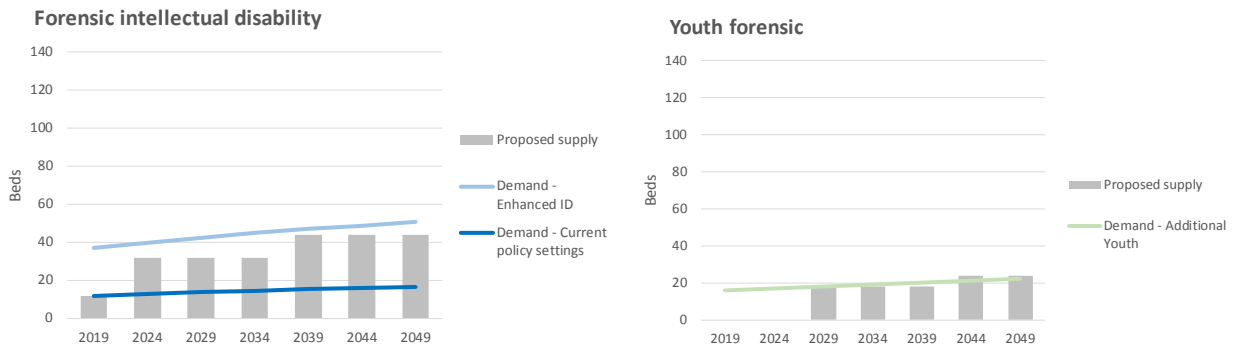


A breakdown of the above chart into the four services is shown in Figure 15 below.

Figure 15 Indicative timing of capacity increases, by service



Mason Clinic Programme Business Case – Economic Case



4.4 Proposed tranches

Overview

The tranches developed for funding and business case purposes will be derived from the stages, and sub-stages, noted above. But they will also be contingent on funding availability.

In effect, our ongoing master planning and business case processes will refine the sequence of sub-stages indicatively described above. Then when determining the content of a given tranche, we will include the next set of items in the sequence up to the total capital funding available at that time. Consideration will also be given to any interdependencies between programme elements that necessitate some sets of works being undertaken together.

The content of each tranche will therefore be determined each tranche at a time. The proposed content of Tranche 1 is described below, and subsequent tranches will be developed in due course.

Tranche 1

Proposed option

We propose that Tranche 1 includes all of Stage 1 (as described above). That is:

- The construction of two new two-storey 30-bed units, for forensic mental health patients, on the newly acquired land at the north end of the site.
- The construction of a two-storey carpark and support building, on the newly acquired land, and the start of the central secure garden.

This is a necessary first step before additional capacity can be contemplated. It is also best undertaken as one development project.

This is expected to cost in the order of \$160m in capex.

Alternative option

We understand that only \$60m in capital funding has currently been prioritised for Tranche 1 of the programme. This will be insufficient to complete Stage 1.

If only \$60m (or a similar amount) is available for Tranche 1, then this tranche will necessarily only comprise a small part of Stage 1. Specific options for a smaller solution will be developed as part of the business case for Tranche 1, but a solution of this scale will inherently only be able to provide, at most, one of the two inpatient units and significantly reduced support, activity and carparking spaces.

While conceivable, we consider that attempting to deliver Stage 1 in multiple tranches (beginning with a first tranche in the order of \$60m), is a significantly inferior solution. It would have a number of significant implications, including the following:

Mason Clinic Programme Business Case – Economic Case

- In order for the first new inpatient unit to be functional, Tranche 1 also needs to include the central buildings, site establishment, infrastructure works, and the main entry drop off area. This means that as much as 75% of the Stage 1 works may need to occur in a smaller solution. Our current analysis indicates that this will not be possible within a \$60m capital envelope.
- In addition to the 60 replacement beds, Stage 1 also includes many other functional spaces including the judicial suite, new front of house and outpatient area, the replacement swimming pool/activity area, centralised therapy functions, and back of house. It will not be possible to provide all of these to a sufficient level as part of a smaller Tranche 1 solution.
- It would require two of the failing units to remain in operation for a number of years longer than necessary. These four units are already exposed to a significant risk of patient and staff harm, which threatens our ability to provide services on an ongoing basis, and we consider that further delay to their replacement to be an unacceptable solution.
- Retaining two of the failing units for longer than necessary has some operational impacts:
 - Staff isolation with some units left 'orphaned'
 - Duplication of reception/ security and judicial areas with consequential safety and staff operational cost issues.
- Leaving two of the failing units in place defers the ability to prepare the site for Stage 2 works, further deferring our ability to provide the urgently needed additional capacity.
- It delays the time when we are able to reconfigure the horizontal infrastructure on the western side of the campus. The full Stage 1 unlocks the existing Mason Clinic site by allowing for unimpeded demolition of the failing buildings. If this occurs as planned in one stage, rather than piecemeal, ground remediation and relocation of significant redundant inground services can be done efficiently, safely and cost-effectively in one process. Sub-stages will add time, complexity and cost.
- It delays our ability to deliver the planned model of care:
 - Either the 'front' (east) unit, or the 'back' (west) unit, would be constructed first. The T1 high secure unit is designed to be at the back, but this is needed as soon as possible. The T2, which is intended to pair operationally with the unit under construction, is at the front. A smaller Tranche 1 would mean that these are not constructed at the same time.
 - Stage 1 is designed as an integrated solution, connecting with the unit under construction, creating 75 beds in a secure environment and a functional operational facility for core forensic services, with improved security and an identifiable 'front door' when opened. A smaller Tranche 1 will defer this integrated solution.
- The balance of the site would be a construction zone for up to two years with the consequential disruption to operations, and service users.
- Construction costs for the second stage will incur a cost premium through additional and abortive work to create the stages; the requirement to interface with an operational building; and the requirement to manage disruption to the newly constructed first stage.

Tranche 2

We expect that Tranche 2 will include:

- Any elements of Stage 1 which were not included in Tranche 1 – Note that we propose that all of Stage 1 is included in Tranche 1.

Mason Clinic Programme Business Case – Economic Case

- The most urgent elements of Stage 2 – Demolition of the four decommissioned units is necessary to enable an efficient reconfiguration of campus-wide infrastructure. Additional capacity for forensic mental health services is urgently needed. The required timing for specialist units for additional and/or enhanced units will depend on future direction from the Ministry of Health.

Mason Clinic Programme Business Case – Commercial Case

5. Commercial Case

The commercial case sets out the process to procure the proposed investment. This section outlines the options and shows it is commercially viable, and appropriately deals with risk.

5.1 Procurement scope

The key services to be procured are the design and construction of the proposed redevelopment projects.

In principle, the maintenance of future facilities may be within the scope of the procurement, depending on the overall approach selected. The procurement of staff, equipment and services to support ongoing patient care is also expected to be in scope.

Procurement of operational requirements will be managed through existing DHB processes.

5.2 Procurement approach

Range of approaches

There are a range of possible models for procuring the redevelopment projects. These vary across a spectrum of public and private sector participation, and according to the upfront specification of risk allocation between the DHB and its contractors. These models include:

- **Traditional models** – Waitemata DHB would individually enter into contracts with an expressly identified risk allocation, such as design bid build (DBB), design, construct and maintain (DCM), or design and construction (D&C). The effectiveness of these arrangements tends to rely on the ability of Waitemata DHB to define its performance requirements prior to tendering and to have a clear identification, understanding and quantification of risks.
- **Relationship based models** – Waitemata DHB would enter into a collaborative relationship agreement with appropriate parties to define requirements, understand risks and undertake the works. These approaches generally collectively share risk on a ‘no fault, no blame’ basis with incentives built in to equitably share additional or reduced value to Waitemata DHB by outcomes actually achieved, thereby encouraging enhanced performance. Such approaches include the Early Contractor Involvement (ECI) model and Alliance contracting.
- **Privately financed models** – Waitemata DHB would enter into contracts with a fixed risk allocation on a whole-of-life basis, such as public-private partnership (PPP) models.
- **Managing contractor procurement models** – Waitemata DHB would appoint a Managing Contractor as the head contractor who would engage subcontractors on behalf of Waitemata DHB to deliver the works and would typically be paid a management fee and incentive payments for achieving target price, schedule and other key parameters.

Many of these approaches have been used for major infrastructure projects in New Zealand. The applicability of each option largely depends on how well the risks and required performance of the projects can be defined.

Specific options

Table 15 describes specific procurement options, within the above models.

Mason Clinic Programme Business Case – Commercial Case

Table 15 Key features of different procurement approaches

Category	Procurement method	Description	Comment
Traditional models	Design bid build (DBB)	<ul style="list-style-type: none"> • Waitemata DHB individually contracts with separate entities for the D&C phases of the project for the segments they are responsible for. 	<ul style="list-style-type: none"> • Commonly used for this type of project.
	Design and construct (D&C)	<ul style="list-style-type: none"> • Waitemata DHB seeks tenders to provide a (typically) fixed price for D&C. 	<ul style="list-style-type: none"> • Commonly used for this type of project. • Less useful where significant design has already been completed, or where the DHB wishes to retain a high level of design involvement.
	Design, construct and maintain (DCM)	<ul style="list-style-type: none"> • Contractor retains responsibility for maintenance, but typically these models do not extend beyond the first major lifecycle phase. 	<ul style="list-style-type: none"> • Less useful where significant design has already been completed, or where the DHB wishes to retain a high level of design involvement. • Waitemata DHB currently has in house delivery of maintenance services.
Relationship based models	Early Contractor Involvement (ECI)	<ul style="list-style-type: none"> • Typically, the preferred ECI contractor is selected under open competition for a whole of project contract (i.e. including design development, design and construction). Typically, agreements are staged, and either a D&C or bid/build contract is entered into with the ECI contractor following the detailed definition phase. A further contract could then be entered into to provide maintenance and (potentially) operations services. 	<ul style="list-style-type: none"> • Generally suited to complex projects where the cost, risks and scope are difficult to define upfront, making a standard construction tender process difficult. • Would result in a larger portion of the contract being subject to a negotiated price. • Could be useful as part of an integrated strategy.
	Alliance	<ul style="list-style-type: none"> • A collaborative Alliance relationship is formed between key project participants, which include Waitemata DHB and non-owner participants (e.g. designer, constructor, other key stakeholders, etc). • Options are available to develop the Target Outturn 	<ul style="list-style-type: none"> • Collaborative approach helps minimise technical risks and mis-alignment of incentives. • Most useful where the technical risks relate to the design. • Limited benefits over traditional models in this context.

Mason Clinic Programme Business Case – Commercial Case

		<p>Cost (TOC) in a competitive environment. However, most alliances have tended to use a single party to</p> <ul style="list-style-type: none"> • develop the TOC. This relies on the owner implementing approaches that create appropriate cost, quality and scope tensions, and the right level of expertise to critically validate the TOC, including risk quantification. • A further contract would likely then be entered into to provide maintenance and (potentially) operations services. • A key feature of Alliances is the gain share/pain share incentive mechanism. 	
Privately financed models	Public Private Partnership (PPP)	<ul style="list-style-type: none"> • A private sector contractor (or consortium) is responsible for the design, construction, operation, maintenance and finance over an extended period (typically 25-30 years). This is a typical long term, whole-of-life approach to infrastructure delivery. • Risk allocation is determined upfront for the period of the contract, including maintaining the infrastructure and providing the services to a pre agreed condition for the duration of the concession. Risk transfer, bundling of whole-of-life costs and incentives from having private finance at risk can drive increased innovation. 	<ul style="list-style-type: none"> • No local hospital facilities have been built under a PPP model, but there is experience internationally. • Limited benefits over traditional models in this context. • Minister of Finance has advised us that there is limited current appetite for PPP structures for an investment of this type.
Other	Privatisation	<ul style="list-style-type: none"> • Full transfer of rights to the private sector through sale, or a sale and lease back arrangement. 	<ul style="list-style-type: none"> • Not appropriate for a project with these characteristics.

Mason Clinic Programme Business Case – Commercial Case

Indicative procurement approach

It is currently expected that the individual projects within each tranche will be procured using a traditional design bid build (DBB) approach. This approach has been successfully used for the recent developments at the Mason Clinic, and is also being used for the ECIB project. There is no reason to use an alternative approach for this programme.

Consideration will be given to methods of using contractor resource as early as possible. The two options considered for ECIB were a traditional early contractor involvement (ECI) method and splitting the procurement into an early works and main works package (with the latter approach preferred).

This will be considered in more detail during the development of the business cases for each tranche of works.

5.3 Other details

Managing competing demand for limited resources

There are other significant building works underway or planned locally and regionally, and the programme is operating in a competitive market. Market conditions are in a state of flux, with current demand and supply side pressures likely to increase as the demand for service design and construction build skills grows in the Auckland market.

With Auckland in the midst of a building boom expected to continue for at least the next 5 years, it is important the programme actively engages with the market in order to secure the appropriate construction resource for this programme of works.

Waitemata DHB is working with the other Northern Region DHBs and the NRA to establish a framework to coordinate timing of investment across the region.

The procurement process will be designed such that it can contribute to increasing the size and skill level of the domestic construction sector workforce and provide employment opportunities to targeted groups, in accordance with direction from Government.

Bundling

Each tranche will be procured separately. The potential timing gap between tranches makes this the most sensible option.

Within each tranche, some projects may be procured together (e.g. the two inpatient units in Stage 1) and others will be procured separately (e.g. the carpark in Stage 1). This will be determined during the business case process for each tranche.

Skills and training

The procurement process will be designed such that it can contribute to increasing the size and skill level of the domestic construction sector workforce and provide employment opportunities to targeted groups, in accordance with direction from the Ministry of Health through its letter of expectations for DHBs.

Health and safety and employment standards

We will follow the Government's guidelines for agencies to improve health and safety, and ensure employment standards are met, in the construction sector. We will work to the following principles:

- Ensure health and safety and employment standards are part of the DNA of every project.
- Take a lead role in improving workplace safety.
- Set clear expectations.

Mason Clinic Programme Business Case – Commercial Case

- Ensure importance of workplace safety is reflected in the criteria to select consultants and contractors.
- Collaborate across the supply chain to manage risks smartly.
- Stay engaged from early in the planning phase to project completion.

Governance of health and safety in projects will be established by utilising the DHB's established health and safety framework. The framework defines the roles and responsibilities of the project leaders to:

- Commit to take the lead role in health and safety standards for the project including safety in design and design reviews.
- Provide a framework to lead, plan, review and improve workplace safety.
- Create strong, effective lines of reporting and communication.
- Establish a collaborative culture that seeks to achieve 'best for project' results.
- Ensure effective monitoring of health and safety performance
- Carry out formal audits and reviews of performance against the expectations and set and follow up on improvement actions.
- Develop the project culture where everyone is responsible for improving workplace safety.

Mason Clinic Programme Business Case – Financial Case

6. Financial Case

The purpose of the Financial Case is to consider the overall affordability of the project over the life of the investment, including the additional funding requirements.

6.1 Expected capital costs

A detailed capital costing has yet to be prepared for the programme as a whole. Cost estimates will be prepared for each of the programme tranches as they are developed.

The programme will begin with a first tranche, for which \$60m in capital funding has been prioritised, although an investment in the order of \$160m is necessary to meet our urgent needs. The business case for Tranche 1 of the programme will include an updated version of this estimate, with an accompanying breakdown.

6.2 Whole-of-life costs

Operating costs (excluding inflation) will broadly move in line with changes to total capacity.

- Stage 1 is not changing the capacity of the Clinic, and hence we do not expect there to be a material change to the ongoing operating costs of the Clinic. Stages 2 and 3 will involve additional capacity, and hence we expect operating costs to rise at that point.
- By the end of Stage 3, the master plan envisages around double the capacity that we have today, and hence we expect that operating costs would also be around double today's levels.
- Detailed operating cost forecasts will be developed as part of the business cases for each tranche.

Future increases to bed capacity will lead to increases in our operational funding. We currently expect that these funding increases will be sufficient to cover any increases in operating costs. Therefore, we do not foresee any issues with being able to sustainably afford to operate the new inpatient facilities following their commissioning.

The proposed programme reflects a staged approach to replacing the failing units and providing additional capacity. It is designed (and will continue to be refined) to provide additional capacity at certain periods over the next 30 years at the time it is needed. Deferring the proposed timing of each development stage would reduce short-term capital requirements, but at the expense of making the capital cost higher when it is ultimately undertaken.

6.3 Funding approach

Waitemata DHB has insufficient reserves to fund this programme in its entirety. While the DHB has used demand management initiatives to delay the need for this investment, we are not able to support the investment through a financial capital contribution, and accordingly Crown equity is required.

The funding of this programme has been discussed with the Ministry of Health and Treasury. We understand that the Government has prioritised \$60m of capital funding for the first tranche of this programme, while funding for subsequent tranches is yet to be prioritised.

Funding for the direct operating costs associated with the new units is expected to be provided by the Crown as per the current method for funding forensic mental health and intellectual disability services, that is via the allocated revenue from the Ministry of Health.

Mason Clinic Programme Business Case – Financial Case

Any increase in capital charge and depreciation that will accrue to the DHB's profit and loss account will not be affordable until national pricing reflects these indirect costs, a lag of at least two years under the current funding model. We understand that no capital charge will be levied on DHB capital projects for the foreseeable future, and we support this decision. Waitemata DHB also requests that a grant be given for the first two years to compensate for the additional depreciation charge incurred.

Mason Clinic Programme Business Case – Management Case

7. Management Case

The management case sets out the planning arrangements required to both ensure successful delivery and to manage programme risks. It demonstrates that the proposed investment is achievable.

It outlines how the programme will be managed, setting out the programme team structure, and the different roles and responsibilities. It also discusses the key risks, constraints and dependencies for the programme.

7.1 Programme governance

Governance and programme management structures have been in place for some time preceding this PBC. Furthermore, work has already been undertaken to reflect clinical input regarding the redevelopment options and the design of the facilities.

Key roles and responsibilities

Waitemata DHB's Board and CEO have overall responsibility and accountability for the programme. The Board and CEO are supported by the Deputy CEO, SRO and Programme Director by way of oversight across general operations.

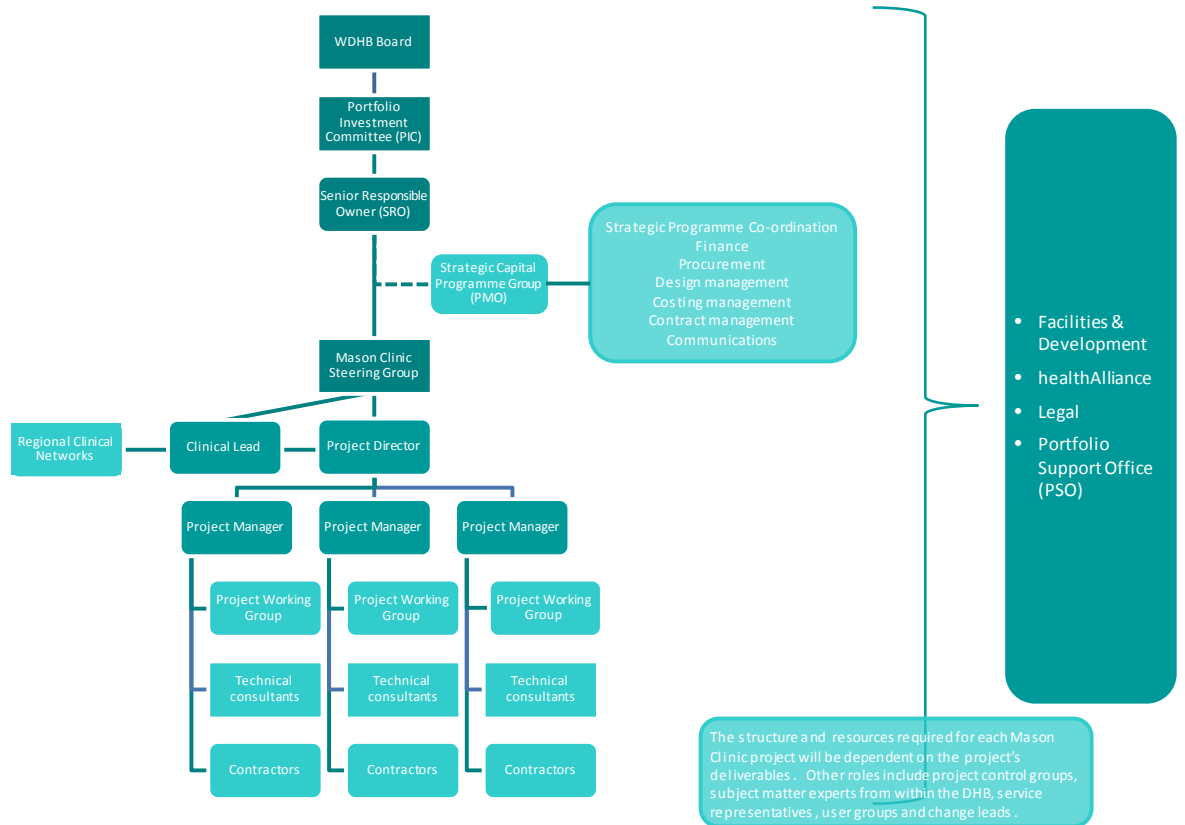
- The Executive Leadership team, and in particular the Deputy CEO, provides oversight of all strategic capital programmes. The Deputy CEO sits on the Programme Steering Group.
- The SRO for the programme is the Director, Strategic Capital Programme Group (SCPG). The SRO has ultimate responsibility for the benefits realisation and long-term sustainability of outputs to the business. They play a key role in communicating the strategic importance of the programme to stakeholders and the senior leadership team.
- A Programme Steering Group has governance responsibility for ensuring that the programme is developed and managed effectively to deliver the expected outcomes, on time and to budget. The Steering Group is chaired by the SRO, and reports directly to the CEO. This ensures that there is clear visibility on progress and issues, and enables direction to be received from the Board as required. It meets at least monthly.
- The SCPG is effectively the programme management office (PMO), and is the forum for the Programme Director to oversee progress and provide leadership and direction for the programme. It also oversees our other facility redevelopment programmes, and ensures consistency across all capital works. It meets monthly.
- A Programme Director will be appointed later this year. They will ensure that the programme's collected project workstreams and activities are properly coordinated, organised, reported on, and tracked in order to deliver the programme outcomes and benefits.
- Project Managers will be appointed in due course for individual projects within each tranche. They will be responsible for planning, managing and controlling the day-to-day work required to achieve designated workstream objectives. They will have delegated responsibility, from the SRO and Steering Group, for managing the development and delivery of the workstream outputs within the agreed time, budget and quality parameters.
- The service change lead for the programme is the Clinical Director of the Mason Clinic. They are responsible for managing the business/operational side of the organisational change that is being delivered, by preparing the organisation for the change, introducing the change through the

Mason Clinic Programme Business Case – Management Case

programme, determining and measuring outcomes/benefits, and monitoring the business/service environment through the transition and post-implementation.

The current governance structure for the programme is illustrated in Figure 16.

Figure 16 Mason Clinic redevelopment programme governance structure



Programme management approach

The DHB has an established programme to build portfolio and project management capability implementing a structured Portfolio Management, Programme Management and Project Management (P3M3) methodology and has invested in a centralised Portfolio Support Office (PSO) and PMO to support the implementation of the programme. The PSO process uses existing organisational, quality and reporting structures to support project and change management.

Waitemata DHB’s change management framework underpins the work of the service change lead, who is responsible for developing a change management plan. The change management plan will identify the nature of change, areas resistant to change, impact of change and strategies to manage change. The plan will have an emphasis on early and ongoing engagement with key stakeholders. The SRO is responsible for ensuring that the change management plan is in place and is effective.

7.2 Programme timeline

Table 14 in the Economic Case set out the indicative timetable for the construction of each inpatient unit envisaged in the master plan, and covers a 30-year timeframe.

Table 16 below provides additional detail for the initial elements of the programme. This will be refined as the programme progresses, with updated timetables included in each tranche-based business case.

Mason Clinic Programme Business Case – Management Case

Table 16 Indicative programme schedule

Task	Indicative date
Programme Business Case	Aug 2019
Tranche 1 (all of Stage 1)	
Business Case	Dec 2019
Design	Early 2020 – Mid 2021
Construction	Mid 2021 – Mid 2023
Tranche 2 (initial elements of Stage 2)	
Business Case	Late 2020
Design	Late 2020 – End 2021
Construction	Early 2022 – End 2023
Subsequent tranches	TBC

7.3 Programme risks

Table 17 describes the main risks to the successful completion of the redevelopment programme. It also notes the likelihood, impact and mitigation measures.

The most notable programme risks are:

- Sufficient funding is not available to deliver the proposed investments, in the timeframe required to eliminate unacceptable risk of service disruption and ensure capacity is sufficient to maintain service levels.
- The projects cannot be delivered in the timeframe required, because of either difficulty accessing contractor resource (at reasonable costs) and/or a lack of internal DHB resources to manage the projects.
- Direction from central agencies regarding the provision of additional services for high and complex needs patients and/or youth forensic services is unclear, susceptible to change, or not provided in a timely way.

Each of the above three items reflects the overall risk of delay to the delivery of the programme. A significant delay will have the following impacts, both of which limit the programme's ability to achieve the investment objectives:

- Increased cost when the projects are eventually delivered (as a result of increased cost escalation)
- An unacceptable risk of major disruption to service delivery, until such time as the projects are delivered.

Table 17 Key programme risks

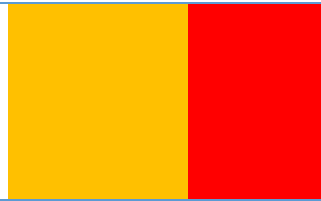
Risk	Likelihood	Impact	Mitigation approach
Funding – Sufficient funding is not available to deliver the proposed investments, in the timeframe required to eliminate unacceptable	Medium	High	<ul style="list-style-type: none"> • Provide compelling business case documentation, supported to robust master planning and other analysis, to CIC in a timely fashion.

Mason Clinic Programme Business Case – Management Case

risk of service disruption and ensure capacity is sufficient to maintain service levels.			<ul style="list-style-type: none"> Engage with key officials and Ministers throughout the design and implementation process. Ensure programme is aligned to local, regional and national planning.
Construction resource – Difficulty accessing contractor resource (at reasonable costs) means that the projects cannot be delivered in the timeframe required.	Medium	High	<ul style="list-style-type: none"> Undertake early testing of market appetite and potential contracting approaches to make the programme more compelling.
Construction timeline – Contractors are unable to deliver the proposed works within the envisaged timeline.	Medium	Medium	<ul style="list-style-type: none"> Have project plans quality assured by independent project management experts. Undertake significant design work in advance. Undertake early market testing with the construction sector.
DHB contractor management resource – A lack of DHB resources to manage contractors means the projects cannot be delivered in the timeframe required.	Medium	High	<ul style="list-style-type: none"> Have robust programme governance and staffing plans in place at the outset of the programme. Ensure key roles are staffed prior to procurement being finalised. Use external project management consultants where appropriate.
Government policy – Direction from central agencies regarding the provision of additional services for high and complex needs patients and/or youth forensic services is unclear, susceptible to change, or not provided in a timely way.	High	High	<ul style="list-style-type: none"> Engage with key officials and Ministers throughout the design and implementation process.
Design and fit-for-purpose – The facilities designed and constructed do not meet our investment objectives.	Low	High	<ul style="list-style-type: none"> Engage clinicians throughout the design and procurement process. Ensure design aligns with legislation, standards and best practice. Ensure design is flexible and future proofed.
Capital costs – The capital costs prove higher than expected.	Medium	High	<ul style="list-style-type: none"> Take a conservative approach to estimating capital costs. Use learnings from recent DHB construction projects regarding actual capital costs and estimates.
Resource consents and future neighbours – Future inpatient	Medium	High	<ul style="list-style-type: none"> Early engagement with MHUD.

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facilities are not included on plans shown to buyers of MHUD land, creating difficulties with obtaining resource consents for those facilities in the future.



- Ensure that future inpatient facilities (as envisaged by the master plan) are included on any wider plans provided to buyers of MHUD land.

7.4 Workforce planning

Workforce planning for the Mason Clinic is undertaken in accordance with the ARFPS's service objectives and models of care, recognising the Mason Clinic's role as a regional facility. All workforce related planning and activity reflects Waitemata DHB's organisational values and strategic intent. We recognise that in order to reflect our promise of best care for everyone, patient and staff experience must play a central part in decision making around workforce planning and development.

Short-term impacts will be limited to a movement to new facilities. As capacity is increased during Stage 2 of the redevelopment, additional staffing will be required.

Key areas for further development include:

- The development and implementation of a detailed staffing plan (subject to linkages and key dependencies identified), which is sensitive to the downstream impact of the Mason Clinic recruitment on other mental health services in the region.
- A recruitment plan and schedule.
- The development of a plan to manage the change in day-to-day models of care from moving to new facilities.
- Provision for learning and development for all employees as appropriate by role type and professional group.
- The consideration of pathway development as well as succession planning within retention and workforce sustainability plans.

Longer term workforce planning for the Mason Clinic will incorporate known and predicted workforce shortages as well as any resulting issues around skill and experience mix that may arise. Planning will also provide sufficient time and resource to ensure staff are able to maintain current registration / practising certificates and meet the requirements of relevant professional bodies.

We will work closely with the NRLTIP 'deep dive' related to workforce planning, as that workstream progresses.

7.5 Engagement

Regional partners and Government

Our regional DHB partners have been thoroughly engaged during the ongoing development of the programme. The other Northern Region DHBs are all supportive of the redevelopment of the Mason Clinic, as a means of providing necessary additional mental health capacity and to enhance service capability.

The Ministry of Health, Treasury and CIC have been engaged at certain points in the development of the programme, and this process will continue.

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Maori

As the Treaty partner, Maori will be engaged as appropriate in the progression of the redevelopment programme.

Programme planning will be informed by He Korowai Oranga, the Maori Health Strategy to establish which facility features, services and models of care can be incorporated to help achieve the best health outcomes for Maori. A consultative approach will be taken through the course of the programme to ensure Maori needs are identified and that engagement achieves the desired outcomes.

Waitemata DHB has a Memorandum of Understanding with Te Runanga o Ngati Whatua and Te Whānau o Waipareira Trust. We will seek advice from these partners on project design and implementation and involvement in programme/project planning.

Representatives of the Maori community will take part in a number of rounds of engagement, as the programme and solutions are further developed.

New Zealand has one of the highest imprisonment rates in the OECD of 220 per 100,000 population, which comprises a disproportionate number of Maori who are imprisoned at a rate of 680 per 100,000. Because of this, the service will continue to be a national and international leader in the way we include cultural dimensions into care planning and delivery, with kaupapa Maori streams of clinical care and cultural paradigms blended with the best that western medicine can offer being available across the service.

Housing and Urban Development Authority and future land owners

We expect to work closely with our neighbours as we all redevelop our sites. This will include being transparent about future plans, working together on boundary issues, and jointly creating an environment which can be enjoyed by both residents and the Mason Clinic patients and staff.

Stakeholders

There are a number of stakeholders that will have an interest in the expected outcomes and should influence the progression of this programme. These include patients and their families, Unitec, other local businesses and residents, Pasifika communities, and our wider community.

It is expected that some of these stakeholders will provide input into the subsequent business cases.

Mason Clinic Redevelopment – Programme Business Case

8. Recommendations

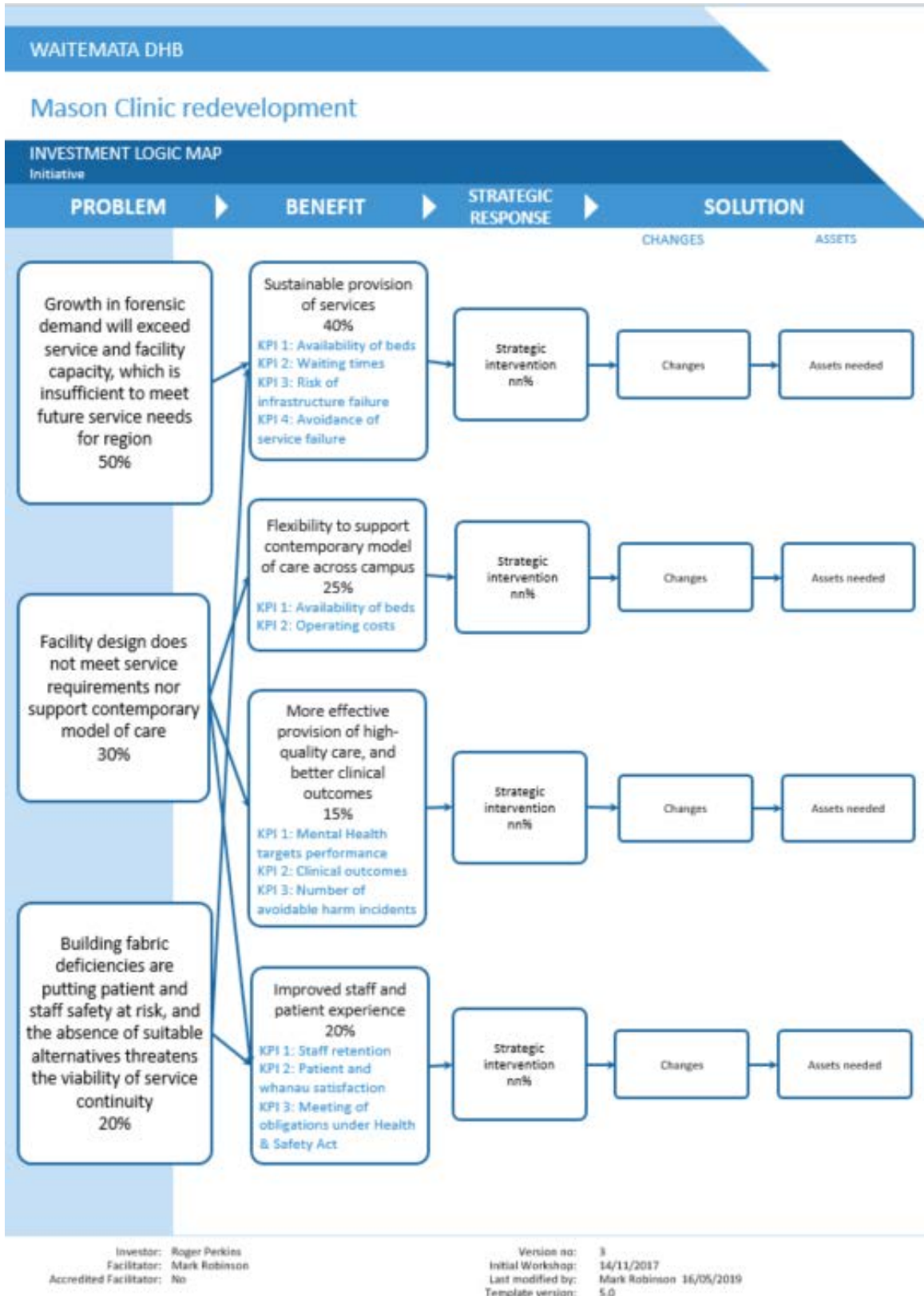
Waitemata DHB recommends that CIC:

1. **Notes** that the Mason Clinic has an urgent need to remediate some of its existing facilities, and that it will need additional capacity in order to continue to provide the same level of services in the future.
2. **Approves** this PBC.
3. **Supports** the development of a Single-Stage Business Case for Tranche 1 of the programme, for which \$60m Crown capital funding has been prioritised, although an investment in the order of \$160m is necessary to meet our urgent needs.

Mason Clinic Redevelopment – Programme Business Case

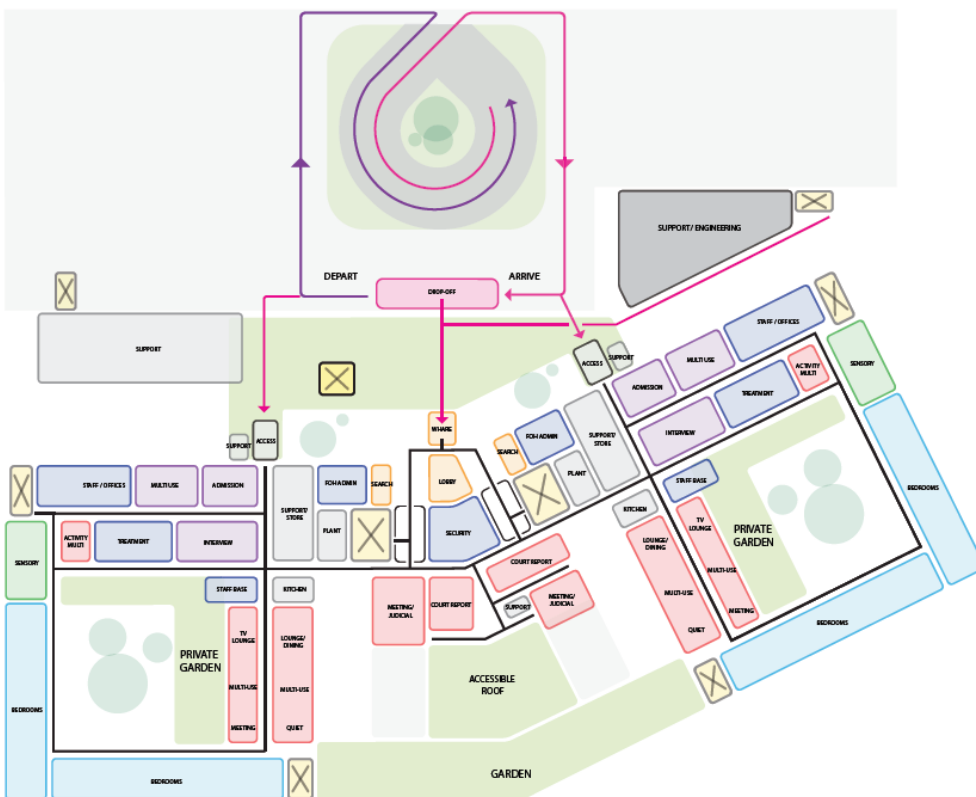
9. Appendices

Appendix A: Investment logic map



Mason Clinic Redevelopment – Programme Business Case

Appendix B: Draft floor plans for Stage 1 inpatient units



Mason Clinic Redevelopment – Programme Business Case

Appendix C: Other relevant documents

Below is a list of external documents which provide supporting information to that included in this PBC, some of which are explicitly referenced in this document. We can provide these documents upon request.

- NRA, NRLTIP (http://www.nra.health.nz/assets/Documents/NRLTIP-Full-DocwCover_Final.pdf)
- Waitemata DHB (2019), Mason Clinic Master plan
- MaynardMarks (2019), Mason Clinic building analysis
- PwC (2019), Mason Clinic demand forecasting
- WT Partnership (26 June 2019), Programme Masterplan Estimate for Mason Clinic.

Office of Hon Dr David Clark



MP for Dunedin North

Minister of Health

Associate Minister of Finance

24 FEB 2020

Professor Judy McGregor
Chair
Waitematā District Health Board
chair@waitematadhb.govt.nz

Dear Professor McGregor

Approval of Waitematā DHB's Tranche One Mason Clinic Business Case

The Minister of Finance and I have considered Waitematā DHB's request for approval of its Tranche One Business Case for the redevelopment of the Mason Clinic facilities.

I am pleased to advise that we have approved a Crown equity contribution of \$60 million towards the first part of this Tranche One work (Option 2). I understand that this funding will enable Waitematā DHB to construct:

- one 30-bed inpatient building on the northern block of land acquired from the Ministry of Housing and Urban Development; with this building containing two 15-bed units, one on each of the first two floors, and plant and administrative spaces on a third floor
- a small amount of shared activity and support spaces adjacent to this new building
- a temporary secure building entry and temporary internal road extension.

We appreciate that as a result of our decision, the DHB will defer the balance of Tranche One, including development of a second 30-bed inpatient building and an activity and clinical support building, to Tranche Two of the Mason Clinic Redevelopment Programme.

I understand this approach will require Waitematā DHB to review the composition of the three tranches currently reflected in its Programme Business Case, including how the overall redevelopment and expansion programme for the Mason Clinic site is integrated and aligned.

The standard approval conditions that apply to this project are detailed in Appendix One.

Congratulations on securing this approval. Please pass on my thanks to your team for their work.

Yours sincerely

A handwritten signature in blue ink, appearing to be 'D. Clark', written over a circular stamp.

Hon Dr David Clark
Minister of Health

cc: Dr Dale Bramley, Chief Executive, Waitematā DHB

Appendix One: Approval Conditions

The conditions of this approval are as follows.

Funding

- a. The project budget for Option 2, Tranche One is not to exceed \$60 million (excluding GST).
- b. The Crown will provide \$60 million in Crown capital equity from the Health Capital Envelope.
- c. In providing this Crown equity injection, Waitematā DHB will continue to its planned breakeven Annual Plan result for 2019-20 and execution thereof.
- d. A cash profile for the draw-down of equity is to be submitted and agreed with officials prior to drawdown. Waitematā DHB will be expected to manage expenditure within the agreed cash profile or provide timely notification of any re-phasing as part of the quarterly assurance reports.
- e. The final draw-down of equity will be made no later than twelve months after project completion or the remaining funds will be forfeited.
- f. Any surplus capital funds from this project are to be returned to the Crown.

Quarterly Project Assurance and Post Completion Reporting

- g. The Senior Responsible Officer for this project will submit quarterly project assurance reports for this project to the Ministry of Health. The project assurance report will, as a minimum, include the following.
 - i. Progress against project milestones.
 - ii. Confirmation of project costs against the approved budget, including a project cash flow.
 - iii. A Crown capital equity request for expenses incurred during the period.
 - iv. Identification of any material risks and planned mitigation.
 - v. Assurance that the contents of the report is backed by a quantity surveyors report or project director's report and that the DHB Board is informed of the contents of the report.
 - vi. Any other information identified as required by the Ministry of Health.
- h. Failure to submit the quarterly assurance report in a timely manner will result in cessation of access to Crown funding.
- i. After the completion of this project the DHB is to provide an Evaluation and Post Implementation Review to the Capital Investment Management Team, DHB Performance, Support and Infrastructure.
- j. A report against the DHB's Benefits Realisation Plan is to be provided 12 months after the work is completed.