COVERSHEET

Minister	Hon Erica Stanford	**Portfolio**	Lead Coordination Minister for the Government's Response to the Royal Commission's Report into Historical Abuse in State Care and in the Care of Faith-based Institutions
Title of Cabinet paper	Implementing a cross-system care safety framework	**Date to be published**	11 September 2026

List of documents that have been proactively released		
Date	**Title**	**Author**
19 August 2026	Implementing a cross-system care safety framework	Office of the Lead Coordination Minister for the Government's Response to the Royal Commission's Report into Historical Abuse in State Care and in the Care of Faith based Institutions
19 August 2026	Implementing a Cross-system Care Safety Framework SOU-26-MIN-0068	Cabinet Office
24 August 2026	Report of the Cabinet Social Outcomes Committee: Period Ended 21 August 2026 CAB-26-MIN-0280	Cabinet Office

Withholding grounds

Information within this document has been withheld as if it had been requested under the Official Information Act 1982. Where this is the case, the reasons for withholding have been listed below. Where information has been withheld, no public interest has been identified that would outweigh the reasons for withholding it.

- section 9(2)(f)(iv) to maintain the current constitutional conventions protecting the confidentiality of advice tendered by or to Ministers and officials

Office of the Lead Coordination Minister for the Government's Response to the Royal Commission's Report into Historical Abuse in State Care and in the Care of Faith-based Institutions

Cabinet Social Outcomes Committee

Implementing a cross-system care safety framework

Proposal

1. This paper seeks Cabinet agreement to progress targeted consultation on options for implementing a cross-system care safety framework, including the potential for overarching legislation, for report back with proposals by April 2027.

Relation to government priorities

2. This paper progresses the Government's response to the Royal Commission of Inquiry into Historical Abuse in State Care and in the Care of Faith-based Institutions (the Royal Commission), including commitments to strengthen the safety, accountability and performance of the care system.

Executive Summary

3. The Lead Co-ordination Minister for the Government's Response to the Royal Commission's Report into Historical Abuse in State Care and in the Care of Faith-based Institutions (the Lead Coordination Minister) and the Ministers for Children, Social Development and Employment, Disability Issues, Education, and the Associate Minister of Health (care ministers) are seeking Cabinet agreement to progress work on proposals for a more durable, system-wide approach to care safety that balances rigour with flexibility (as reflected in options two and three of Appendix Two).

4. Agencies continue to progress important sector-specific and cross-agency investment and reform activity, including under the oversight of the 'Safety in Care' System Leadership Group, in support of Objective Two of the Crown Response Plan (Make the care system safe).

5. However, agencies have found fragmented visibility, accountability and responsiveness across the care system, with no overarching mechanism for setting and assuring common requirements and expectations of safe care.

6. Subject to Cabinet agreement, care ministers will report back by April 2027 with more detailed proposals for implementing cross-system requirements and expectations, informed by targeted consultation (including on a care safety framework, outlined in draft as Appendix One, and potential legislative options).

Background: The Royal Commission recommended large scale changes to the care system and the response is underway

7. In July 2024, the Royal Commission made recommendations for large scale changes to the care system to address continued abuse in care today. It considered "a care safety regulatory system is urgently needed to ensure all care settings are safe" (*Whanaketia*, Part 9).

8. In May 2025, we, as Government, released our multi-year response to the Royal Commission's recommendations (the Crown Response Plan). Objective Two of the plan is to make the care system safe.

9. The first phase of our response has involved addressing known capability gaps and strengthening existing care safety functions. Through Budget 2025, a significant investment ($188 million over four years) has been, or is being, made in initiatives to improve care safety – including to build a diverse, capable and safe care workforce, empower families, whānau and communities to prevent entry into care, recognise and respond to abuse in care, and improve recordkeeping and mental health care.

10. This included an operating contingency of $70.88 million over four years (from 2025/26 – 2028/29) and $21.5 million in outyears, to build a safe and capable care workforce. 9(2)(f)(iv) [redacted] Care ministers have also commissioned an update and advice in March 2027 on system-wide enablers for vetting within the care sector (i.e. potential pathways for improving workforce safety checking)

11. As part of this initial phase of our response, we also committed to responding to the Royal Commission's recommendations for structural and other system-wide changes, specifically, to establish a national care safety regulatory framework, which includes (but is not limited to):

    - a set of Care Safety Principles (recommendation 39);
    - an overarching National Care Safety Strategy (recommendation 40);
    - a single Care Safe Agency with 18 specified functions (recommendation 41);
    - new legislation (a Care Safety Act) (recommendation 45); and
    - a duty of care, and associated penalties and sanctions (recommendation 47).

12. In December 2025, Cabinet agreed to the establishment of a baseline set of consistent core safety requirements and expectations across care settings, driven by collective system leadership, (through a new 'Safety in Care' System Leadership Group) rather than the creation of a new Care Safe Agency (at least initially).

13. Cabinet invited the Lead Coordination Minister to report back by August 2026 on a cross-agency programme of work on care safety requirements, implementation and delivery options, and timeframes for any legislative changes [CAB-25-MIN-0451 refers].

14. The Crown Response Office and care agencies are also undertaking foundational work to support future care safety monitoring and reporting. This includes the development of system-wide indicators and assessment of available data so that system leaders are better informed about whether people in care are safe and where to focus measures to address any issues.

A draft care safety framework has been developed as a starting point for what a safe care system should look like

15. The Crown Response Office and care agencies have jointly developed a draft care safety framework (Appendix One) setting out what a safe care system should look like, which care ministers have received and noted. It includes the following core elements, which draw from and build on the Royal Commission's recommendations for what a safe care system requires:

    a) overarching guiding principles;

    b) core safety functions; and

    c) outcomes and benchmarks to guide expectations setting and implementation across care settings.

16. Agencies have incorporated the concepts outlined in the Royal Commission's recommended 12 principles and sub-principles (recommendation 39) throughout the framework as appropriate (including, but not only, in the overarching guiding principles). This approach reflects that some of the detail is more operational and would sit more usefully within outcomes, requirements and expectations, and/or broader implementation tools.

17. People receiving care should expect to be safe and free from abuse and neglect, no matter where they are receiving that care. The draft framework is therefore designed to support common cross-system expectations. It also allows flexibility in implementation across different care settings given the diversity of needs across those care settings and their different relative risk profiles. The draft framework will be further refined, including through proposed targeted consultation (see below).

This work has identified gaps where a stronger cross-system response is needed

18. As outlined in Appendix One, safety functions are relatively well-established in some parts of the care system (e.g. in Oranga Tamariki residences, compulsory care settings in mental health, and larger residential care environments in health and disability settings) though there are ongoing issues with the maturity of some of those functions. In other settings where people also face high levels of risk and vulnerability those functions are not consistently in place or are under-developed, for example in health and disability residential care settings with fewer than five beds, home support services (funded through the health, disability and Accident Compensation

Corporation sectors), and children and young people in 'transitional' or temporary care settings (such as motels).

19. The Royal Commission and recent insights from independent monitors and other stakeholders have also identified persistent cross-system gaps, in particular:

    i. *Insufficient visibility of abuse and harm in some care settings and at a system level*. Harm can go unreported or undetected, and we still have no single, credible estimate of how much abuse and neglect may be occurring across the care system – due to limited, incomparable and inconsistent data collection, recordkeeping, and information sharing. The cross-agency work programme on ensuring allegations of abuse and neglect in care settings are reported, visible and responded to appropriately, currently being overseen by the 'Safety in Care' Leadership Group, will address aspects of this.

    ii. *Fragmented and diffuse mechanisms for holding the system, and those within it, accountable for its safe performance.* Current measures available to respond to abuse and neglect are only partial, inconsistently applied, and do not sufficiently focus on the prevention of harm.

    iii. *Limited evidence that the system is listening, learning, and adapting to the needs of those in care in a context where care needs and settings are becoming more complex*. Complaints and feedback processes are hard to navigate and slow to resolve, some sectors lack access to advocates, and the system has limited ability to collectively identify and respond to emerging risks, trends and issues.

20. There is an opportunity, in parallel with work already underway to strengthen these care safety functions, to establish a more robust mechanism (including possible regulatory change) for driving system-wide change.

Care ministers propose targeted consultation on two options to deliver the system change envisaged by Cabinet and the Royal Commission

Agencies have considered a spectrum of options for implementing these cross-system care safety requirements and expectations

21. As a Government, we have choices to make about the approach we take to lifting care safety. We can continue with incremental changes across different care sectors to progressively align care safety requirements, or we can progress stronger system-level mechanisms to drive change.

22. Officials have considered and analysed four options for implementing cross-system requirements and expectations, as set out in Appendix Two:

    i. Option One - primarily agency driven implementation (largely status quo): relying on the 'Safety in Care' System Leadership Group for collective decision-making given effect to via individual agency accountabilities and reporting through the Crown Response Plan;

ii. Option Two - mix of collective and agency driven implementation under sector-specific legislation: shared strategic direction and priorities for care safety set by Cabinet, a multi-year cross-agency care safety plan, and continuous improvement governed by the 'Safety in Care' System Leadership Group;

iii. Option Three - high-level cross-sector legislative architecture that enables setting specific requirements: overarching legislated principles and potential duty of care alongside associated enforcement mechanisms and system-wide reporting; and

iv. Option Four - prescriptive and detailed cross-sector legislative requirements: legislating for a duty of care and uniform rules and standards across care settings.

23. All options include some degree of consistent care safety expectations but vary in how detailed and prescriptive those requirements are, and what approach is taken to mandating and enforcing the requirements.

24. Notably, options three and four involve legislative mechanisms to enforce care safety requirements. Establishing an overarching legislative mechanism would allow for a potential statutory duty of care across the care system , as recommended by the Royal Commission (*Whanaketia,* recommendation 47*)* to: create clear cross-system accountability for preventing harm and promoting safety; apply to all state and faith-based entities providing care; and allow for a range of meaningful offences, sanctions, and penalties for non-compliance.

I am seeking Cabinet agreement to targeted consultation on implementation options that balance rigour and consistency with flexibility

25. Following agencies' assessment against the criteria set out in Appendix Two, care ministers have been advised that:

- option one is unlikely to result in the system change envisaged by the Royal Commission and Cabinet - not allowing for the system-wide accountability and ability to set consistent (but flexible) expectations;
- options two (a more collective approach with shared strategic direction) and three (a high-level legislative architecture) are considered to strike the right balance between flexibility and consistency in care safety; requirements across care settings, and provide stronger mechanisms to hold the system to account; and
- option four is not currently recommended on the basis that an overly prescriptive and detailed approach does not enable effective implementation across highly diverse care settings.

26. On behalf of care ministers, I am therefore seeking Cabinet agreement to targeted consultation, focused primarily on the approaches outlined under options two and three. This reflects that option one reflects the status quo and

option four largely reflects the Royal Commission's recommendations (which were widely consulted), as well as agencies' advice to develop a balanced approach per options two and three.

27. Targeted consultation will inform more detailed advice on the range of options and a preferred implementation approach, which I will report back to Cabinet with by April 2027. This will include advice on which Royal Commission recommendations will be progressed through the recommended approach and which, if any, are recommended to be declined.

28. State care settings in scope of the Royal Commission's inquiry will be covered by any proposed implementation approach, as a starting point. Additionally, care ministers have agreed that officials consider inclusion of aged care settings and non-state funded care settings as part of the next phase of work. This reflects similarities in levels of risk and vulnerability in these settings and those within the Royal Commission's scope. Specific parameters will need to be determined iteratively, dependent on a number of factors, including the implementation approach to be progressed. Targeted consultation would be undertaken by November 2026 and would:

    - build on the draft framework set out in Appendix One;
    - inform advice on both legislative and non-legislative mechanisms for implementing care safety requirements;
    - consider implications for the aged care sector and non-state-funded care, in addition to settings included in the Royal Commission's scope (agreed by care ministers in June 2026); and
    - involve a range of potential impacted stakeholders including but not limited to agencies, care providers, people with recent care experience, oversight and monitoring bodies, peak bodies and advocates as appropriate. These may include, for example, Social Service Providers Aotearoa, Aged Care New Zealand, the Disabled People's Organisations Coalition, faith-based entities, and Pacific and kaupapa Māori providers.

29. As Lead Coordination Minister, in consultation with other care ministers where necessary, I will take detailed decisions on any targeted consultation, including who will be consulted, the content, sequencing, and other related matters as required. Consultation will utilise, wherever possible, existing advisory groups and engagement forums.

30. Agencies will continue to work together to ensure alignment with related agency work programmes, such as the Dame Karen Poutasi Response, and the review of Part 3 of the Children's Act.

This recommendation takes account of feedback received from the Ministerial Advisory Group

31. I have received advice from the Abuse Inquiry Response Ministerial Advisory Group (MAG), who provide me with independent advice on the Crown Response, about these proposals.

32. The MAG considers that a stronger regulatory system is needed to drive compliance with the existing requirements, as well as ensuring the success of any proposed additions to the existing framework. It supports introducing a statutory duty of care that sits across the care system, while maintaining flexibility of implementation (in line with option three of Appendix Two). It considers that such an approach shifts the focus to prevention and ensures consistency in accountability.

33. It also provided advice on the design and monitoring of the duty of care that can inform further proposals to Cabinet following targeted consultation.

Next steps

34. Subject to Cabinet agreement, officials will undertake targeted consultation through late 2026.

35. The Lead Coordination Minister will report back to Cabinet by April 2027 on:

    i. preferred implementation approach (including legislative options);

    ii. system scope;

    iii. accountability and enforcement mechanisms;

    iv. progress addressing priority gaps; and

    v. financial implications.

Cost-of-living Implications

36. There are no cost-of-living implications from the proposals in this paper.

Financial Implications

37. There are no immediate financial implications arising from this paper. The April 2027 report back will include initial advice on some potential costs associated with strengthening care safety functions to meet any cross-system care safety requirements and expectations. The scale and timing of those costs will depend on decisions Ministers take regarding the substance of those requirements and expectations and approach to their implementation.

Legislative Implications

38. Subject to Cabinet agreement, targeted consultation will include options that would involve legislative change. Any potential legislative proposals are

expected to be brought to Cabinet for policy decisions by April 2027, following consultation, subject to legislative programme priorities.

Impact Analysis

Regulatory Impact Statement

39. Impact analysis requirements do not apply at this stage, as no specific regulatory decisions are being sought.

Population Implications

40. The Royal Commission found that Māori, disabled people (including tāngata whaikaha) and Pacific people have been disproportionately affected by abuse in State and faith-based care. Safeguards for adults in care have been identified as a major gap in the current system.

41. The Royal Commission also found that women and girls experienced distinct forms of abuse and harm in State and faith-based care including sexual abuse, reproductive coercion and related forms of mistreatment. Furthermore, people who sit at the intersection of multiple population groups can experience compounded forms of discrimination and abuse.

42. The proposals in this paper have potential to benefit people at heightened risk of abuse in care, if their voices are represented in design process and implementation is culturally responsive. Targeted consultation, if agreed, will include a range of potential impacted stakeholders including but not limited to care providers, people with recent care experience, oversight and monitoring bodies, advocates and population focused agencies.

Human Rights

43. The Royal Commission recommended in *He Purapura Ora* recommendation 3 and *Whanaketia* recommendations 15 and 118 that the Crown uphold the rights agreed under various international human rights instruments. The Crown has accepted the intent of these recommendations, reaffirming the Crown's international legal obligations to uphold the rights agreed under international human rights instruments that New Zealand is party to.

44. The proposals in this paper are consistent with the New Zealand Bill of Rights Act 1990, the Human Rights Act 1993, UN Convention on the Rights of the Child, Convention on the Rights of Persons with Disabilities, United Nations Declaration on the Rights of Indigenous Peoples, Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment or any other international human rights instruments to which New Zealand is a signatory.

45. The effective implementation of a cross-system care safety framework would advance the safety and wellbeing of populations including but not limited to Māori and Pacific peoples, disabled people, and children and young people. The proposed framework aligns with principles upheld by multiple human rights instruments, including through reflecting that affected groups have a

voice in decisions that affect them, and protection from exclusion, harm and disadvantage. Proposed targeted consultation should further strengthen how the framework and its implementation aligns with New Zealand's human rights obligations.

Use of External Resources

46. No external resources have been used to develop this proposal, nor are any anticipated to be used to develop or deliver any further work described here.

Consultation

47. This paper was developed in consultation with the Ministries of Education, Social Development, Health, and Disabled People – Whaikaha, as well as Oranga Tamariki – the Ministry for Children, and Te Puni Kōkiri.

48. The Ministries of Justice, of Business, Innovation and Employment (Accident Compensation), for Regulation, and for Pacific Peoples, as well as the New Zealand Police, the Department of Corrections, the Social Investment Agency, and the Education Review Office were also consulted. The Department of Prime Minister and Cabinet and the Treasury were informed.

Communications

49. Communications may accompany proactive release of this paper.

50. Any communications made to progress the next phase of work, including targeted consultation, will be considered by the Lead Coordination Minister.

Proactive Release

51. I propose to proactively release this paper, with appropriate withholdings, on the Crown Response Office website and advise stakeholders of its release via the Crown Response Office's usual communications mechanisms.

Recommendations

The Lead Coordination Minister for the Government's Response to the Royal Commission's Report into Historical Abuse in State Care and in the Care of Faith-based Institutions recommends that the Committee:

1 **note** the first phase of work to strengthen the care system is underway, including Budget 2025 investments to address known gaps and strengthen existing care safety functions;

2 **note** this paper provides a report back by August 2026 on a cross-agency work programme to build and strengthen care safety with an initial focus on the development of care safety requirements, implementation and delivery options, and timeframes for any legislative changes [CAB-23-MIN-0365];

3 **note** the draft care safety framework (Appendix One) and implementation options for care safety requirements and expectations (Appendix Two);

4 **agree** to officials undertaking targeted consultation in late 2026 on the draft care safety framework and its implementation, with a focus on options two and three (including the potential for overarching legislation) to inform more detailed advice on the range of options and a preferred implementation approach;

5 **note** the Ministerial Advisory Group considers a stronger regulatory system is needed to drive compliance with requirements and supports introducing a statutory duty of care that sits across the care system, while maintaining flexibility of implementation (in line with option three in Appendix Two);

6 **note** the Lead Coordination Minister will take detailed decisions on targeted consultation to inform design and implementation of a cross-system care safety framework, including around content, sequencing and other related matters as required; and

7 **invite** the Lead Coordination Minister to report back by April 2027, informed by insights from targeted consultation, on:

7.1 preferred implementation approach (including legislative options);

7.2 system scope;

7.3 accountability and enforcement mechanisms; and

7.4 progress addressing priority gaps.

Authorised for lodgement

Hon Erica Stanford

The Lead Coordination Minister for the Government's Response to the Royal Commission's Report into Historical Abuse in State Care and in the Care of Faith-based Institutions recommends that the Committee

Appendices

One: Draft cross-system care safety framework

Two: Options for implementing a cross-system care safety framework

APPENDIX ONE: What is safe care and how far are we? (Draft cross-system care safety framework to be informed by consultation)

[Overarching Care Safety Principles: TBC based on either subset of the Royal Commission principles which are more principle-level, (while those that work at an operational level are woven into the work on care safety requirements and expectations) or develop a smaller set of consolidated principles that incorporates all the concepts in the Royal Commission's 12

Functions

Advocacy / Voice	Feedback, concerns and complaints	Rules, standards, policies, procedures	Approval to provide care	Workforce assurance	Active monitoring and response	Independent oversight	Enforcement

Outcomes and potential benchmarks

having a meaningful voice in decisions about own care	ease in raising concerns, and confidence they are addressed promptly and thoroughly, in a safe way	clear expectations and standards upholding safety, dignity and human rights are in place and met	all care settings are assessed for safety before care is provided	those providing care are safe, suitable and equipped and supported to deliver safe care	timely processes for monitoring, including internal monitoring, reporting, continuous learning and accountability	independent monitoring to identify risks of harm early with mechanisms to ensure that those risks or concerns are acted on	being clear on roles and responsibilities, and the consequences for not meeting them

That can look like

• supporting identity • incorporating lived experience knowledge • advocacy • consent-based • accessibility • documenting decision-making • accessible tools for communication • family/whānau involvement • an array of opportunities and formats for feedback • frequent feedback review • collective support/peer groups and helplines	• confidentiality • anonymous pathways • cultural safety • accessible, visible, and widely promoted information on how to lay complaints • appropriate languages and formats • systematic recordkeeping • responsiveness and updates • regular review and improvement of complaints resolution processes • 24/7 pathways for complaints	• leadership assurance • staff compliance • user-inclusive, safe, and timely designs of policies and procedures • information security • planning support for providers • default safeguarding planning • safeguards increasing proportionately to risk • mandatory reporting requirements • continuous improvement as part of feedback loop	• contractual safeguards proportionate to risks • providers check their own compliance • checking organisations regularly • oversight is increased with risk • family-based carers have training and support • placement assessments	• workforce vetting • ongoing suitability assessments • information sharing for concerns • induction and ongoing safeguarding training • fit and proper persons in governance roles • clear allegation reporting pathways • prompt action to respond to concerns • regular reviews of assurance data • mechanisms to prevent unsafe people from moving between providers	• incident reporting • escalation procedures • clear reporting timeframes • incident notification • reporting capability • secure recordkeeping • real-time monitoring • information sharing • data informs response and improvement • any restrictive practices externally reviewed • whānau feedback loops • regular visits from social workers	• unrestricted personal visits (unless clearly justified) • frequent contact with whānau • independent care oversight • full oversight access • private oversight interviews • risk-responsive oversight visits • unannounced oversight visits • cooperation with investigations • public oversight reporting	• graduated enforcement framework • timely remedial action • statutory duty of care • criminal penalties for serious wrongdoing, eg of practice

Delivered in a risk proportionate way, subject to setting-specific considerations around...

level of dependence	level of isolation or visibility	the mix of care recipients (including children or young people)	intensity and duration of care	closed vs open environments	power imbalances

Areas for focus (DRAFT, to be informed by consultation)

Gaps: By closest fit, though many gaps are cross-functional

Advocacy / Voice	Feedback, concerns and complaints	Rules, standards, policies & procedures	Approval to provide care	Workforce assurance	Internal monitoring & response	Independent oversight	Enforcement
• Lived experience knowledge not consistently build into decision-making • Barriers to people having their voice heard in some settings (e.g. mental health) • Advocacy gaps in disability care settings • Limited access to effective, independent advocacy (disability, aged care, compulsory care). • Inconsistent proactive provision of information on people's rights.	• Fragmented pathways for raising concerns • Complaints pathways not always made clear, especially between or where there is multiple settings involved • Weak feedback loops between monitoring, complaints, and system improvement	• Unclear or inconsistent reporting obligations and practices in certain areas • Existing rules and standards not consistently followed in practice • Trade-offs made between accessibility, affordability, and safety requirements. • "Grey zones" between settings and transition points between services • Not always sufficient staffing	• Some care contexts (e.g. respite, end-of-life, in-home, s238(1)(e) OT Act police cell custody) not clearly covered by appropriate safeguards • Regulatory gap for small health and disability residential care settings, and informal care arrangements	• Inconsistent vetting, training, and suitability checks across sectors and roles • Workforce assurance gaps in informal/devolved and family-based care • Practical workforce constraints (recruitment, retention, pay) affecting safety • Workforce assurance gaps in individualised funding arrangements	• In some areas, limited use of lived-experience data, missing certain harms • Data is often aggregated, missing key differences in outcomes (e.g. disability), leaving some risks hidden • Insufficient real-time data on risks, incidents, and trends • Could be better enabled to use technologies safely/ appropriately (eg CCTV). • Sometimes unclear who is responsible for acting on disclosure of harm	• Lack of oversight of privately provided care (e.g.: in-home aged care, private schools) • Lack of mechanisms to share monitoring learnings or insights across the system • Outside of the Oranga Tamariki system, lack of enabling provisions for information-sharing and referrals across sectors	• Over-reliance on contracts rather than statutory enforcement powers • Lack of graduated enforcement options (limited "middle" interventions short of closure)

Relevant ongoing action

- DKP mandatory reporting and training
- OT review of feedback and complaints model
- Health funding review for aged care
- Part 3 review of the Children's Act
- 9(2)(f)(iv)
- DSS Bill – sets a foundational authorising framework
- Carers Strategy Action Plan supporting carers to deliver safe care, and build data and evidence to improve services
- Mental Health Bill – create a modern legislative framework for compulsory mental health care.

Care-system-wide initiatives already in progress to address some gaps, overseen by 'Safety in Care' System Leadership Group

- Care workforce capability framework and survey – will support effective implementation of functions
- Work to understand what data is available across these - data and reporting framework

Some core issues within and across functions could benefit from prioritisation. In particular, those relating to accountability (responsibilities, including to ensure safety and consequences for not fulfilling those), cross-system visibility (information sharing, and cohesive and thorough oversight), and ensuring voice is sought, listened to and responded to (consistent advocacy, ability to be heard meaningfully, and cross-system continuous learning and improvement). Many of these overlap with Royal Commission recommendations. There are other gaps that can be considered sector-by-sector.

We are exploring options to respond to these gaps, but any cross-system approach could also provide a potential means to set and monitor expectations within any functions as an ongoing way to gauge where parts of the system should be focusing to support safe care.

APPENDIX TWO: Options for implementing a cross-system care safety framework

Drivers sit under (existing) sector-specific legislation

Overarching cross-system legislative drivers

OPTION	1 Primarily agency driven implementation (largely status quo)	2 Mix of collective and agency driven implementation under sector-specific legislation	3 High-level cross-sector legislative architecture that enables setting specific requirements	4 Prescriptive and detailed cross-sector legislative requirements
CHANGE LEVERS	▪ Common Cabinet-mandated expectations ▪ Light touch collective decision-making by Chief Executives as required ▪ Existing sanctions and enforcement ▪ Agencies largely progress individual work programmes ▪ Reporting through regular updates on progress against recommendations in the Crown Response Plan	▪ Common Cabinet-mandated principles and expectations ▪ Collective Chief Executive governance, with shared strategic direction and priorities for care safety and multi-year cross-agency care safety plan ▪ Development of shared tools, policies, processes, training and guidance ▪ Care safety system performance and reporting ▪ System-wide continuous improvement	▪ High-level common expectations set out in legislation (including principles and potential duty of care) ▪ New sanctions and enforcement powers ▪ Expand powers of some independent monitors (to be confirmed) ▪ Potential to apply to non-State contexts ▪ Enables setting and sector-specific standards and responses ▪ System-wide, consistent governance and reporting ▪ Potential safety checking and monitoring shared services	▪ Uniform and detailed rules, standards, accreditation, and vetting set out in a single, overarching, piece of legislation including a duty of care ▪ Prescribed regulator/s, penalties and sanctions for enforcement of centrally set standards ▪ Potential to apply to non-State contexts ▪ Centralised registration and safety checking ▪ Legislative requirement for a system wide strategy
NOTES	Could comprise first phase of change for 1-2 years before exploring more substantial change as per options 2 and 3	**Recommend progressing** to further analysis/consultation (Note could leave open the possibility to progress option 3 at a later date)	**Recommend progressing** to further analysis/ consultation (Note could combine with elements of option 2)	Not recommended due to risks associated with large-scale system disruption and of inflexible legislative requirements that would not respond to diversity of care settings and needs

CONSISTENCY extent to which people in care have the same level of safeguards across the system

Low – Medium – High | Low – Medium – High | Low – Medium – High | Low – Medium – High

FLEXIBILITY extent to which safeguards can be adapted to respond to the care context

Low – Medium – High | Low – Medium – High | Low – Medium – High | Low – Medium – High

COST extent of resource required for implementation

Lower – Medium – Higher | Lower – Medium – Higher | Lower – Medium – Higher | Lower – Medium – Higher

PACE potential timeframes to deliver intended outcomes

Slower – Medium – Faster | Slower – Medium – Faster | Slower – Medium – Faster | Slower – Medium – Faster

ACCOUNTABILITY new oversight and enforcement levers

Low – Moderate – Strong | Weak – Moderate – Strong | Weak – Moderate – Strong | Weak – Moderate – Strong

RCOI ALIGNMENT degree of alignment to the RCOI vision and recommendations

Low – Moderate – Strong | Weak – Moderate – Strong | Weak – Moderate – Strong | Weak – Moderate – Strong

EFFECTIVENESS likely impact for achieving desired care safety outcomes (to be informed by consultation)

Low – Moderate – Strong | Weak – Moderate – Strong | Weak – Moderate – Strong | Weak – Moderate – Strong

Decisions have already been taken by Cabinet to not implement the 'Care Safe Act' (in the short term) and, for example, accompanying 'Care Safe Agency' as the Royal Commission had envisioned

Cabinet Social Outcomes Committee

Minute of Decision

Implementing a Cross-system Care Safety Framework

Portfolio **Government's Response to the Royal Commission's Report into Historical Abuse in State Care and in the Care of Faith-based Institutions**

On 19 August 2026, the Cabinet Social Outcomes Committee:

1 **noted** that the first phase of work to strengthen the care system is underway, including Budget 2025 investments to address known gaps and strengthen existing care safety functions;

2 **noted** that the paper under SOU-26-SUB-0068 provides a report back by August 2026 on a cross-agency work programme to build and strengthen care safety with an initial focus on the development of care safety requirements, implementation and delivery options, and timeframes for any legislative changes [SOU-25-MIN-0173];

3 **noted** the draft care safety framework and implementation options for care safety requirements and expectations, attached to the submission under SOU-26-SUB-0068 as Appendices One and Two respectively;

4 **agreed** to officials undertaking targeted consultation in late 2026 on the draft care safety framework and its implementation, with a focus on options two and three (including the potential for overarching legislation) to inform more detailed advice on the range of options and a preferred implementation approach;

5 **noted** that the Ministerial Advisory Group considers a stronger regulatory system is needed to drive compliance with requirements and supports introducing a statutory duty of care that sits across the care system, while maintaining flexibility of implementation (in line with option three in Appendix Two);

6 **noted** that the Lead Coordination Minister will take detailed decisions on targeted consultation to inform design and implementation of a cross-system care safety framework, including around content, sequencing and other related matters as required;

7 **invited** the Lead Coordination Minister to report back by April 2027, informed by insights from targeted consultation, on:

7.1 preferred implementation approach (including legislative options);

7.2 system scope;

7.3 accountability and enforcement mechanisms; and

7.4 progress addressing priority gaps.

Sam Moffett
Committee Secretary

Present:
Hon David Seymour
Rt Hon Winston Peters
Hon Louise Upston (Chair)
Hon Nicola Willis
Hon Erica Stanford
Hon Matt Doocey
Hon Nicole McKee
Hon Casey Costello
Hon Karen Chhour
Hon Nicola Grigg
Hon Scott Simpson

Officials present from:
Officials Committee for SOU

Cabinet

Minute of Decision

Report of the Cabinet Social Outcomes Committee: Period Ended 21 August 2026

On 24 August 2026, Cabinet made the following decisions on the work of the Cabinet Social Outcomes Committee for the period ended 21 August 2026:

SOU-26-MIN-0068	**Implementing a Cross-system Care Safety Framework** Portfolio: Government's Response to the Royal Commission's Report into Historical Abuse in State Care and in the Care of Faith-based Institutions	CONFIRMED

[redacted]

Rachel Hayward
Secretary of the Cabinet