Canterbury
District Health Board
Te Poari Hauora ō Waitaha

CORPORATE OFFICE

Level 1
32 Oxford Terrace
Christchurch Central
CHRISTCHURCH 8011

Telephone: 0064 3 364 4160
Fax: 0064 3 364 4165
Ralph.LaSalle@cdhb.health.nz

9 November 2020

9(2)(a) [redacted]

RE Official information request CDHB 10382

I refer to your email dated 10 August 2020 requesting the following information under the Official Information Act from Canterbury DHB regarding the recent sudden resignation of CEO David Meates and the role that funding concerns and pressures may have contributed to it. Specifically:

1. **Copies of correspondence between Mr Meates and the DHB board chairs (Dr John Wood and then Sir John Hansen) between 1 January 2019 and 5 August 2020.**

Please find attached as **Appendix 1,** correspondence between Mr David Meates and DHB Board Chair Sir John Hansen between June and August 2020.

2. **Copies of correspondence between Mr Meates and crown monitor Lester Levy between 14 June 2019 and 5 August 2020.**

Please find attached as **Appendix 2,** correspondence between Mr David Meates and crown monitor Lester Levy between June and August 2020.

3. **Copies of correspondence between Mr Meates and the Ministry of Health between 1 January 2019 and 5 August 2020.**

Please find attached as **Appendix 3,** correspondence between Mr David Meates and the Ministry of Health between June and August 2020.

To provide information prior to June this year would require substantial collation and research, we are therefore declining to go back beyond that date pursuant to section 18(f) of the Official Information Act. The information requested in your above questions totalled nearly 3000 pages and took 30+ hours to collate. We calculate it would have taken a substantial number of extra hours to review, sort according to the scope of your request and then redact under the provisions of the Act.

We have provided information specifically between David Meates, John Hansen, Lester Levy and the Ministry of Health. We are withholding correspondence where David Meates was copied in or was part

of a substantial email trail to all DHB Chief Executives. We have also redacted information pursuant to section 9(2)(a) of the Official Information Act i.e. "*…to protect the privacy of natural persons, including those deceased"* and section 9(2)(i)(j) i.e. *"….to enable a Minister, department or organisation holding information to carry out commercial activities or negotiations."* We have also removed information we consider to 'Out of Scope' of your request.

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

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

Yours sincerely

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

APPENDIX 1

Kathleen Smitheram

From: John Hansen
Sent: Friday, 5 June 2020 11:11 AM
To: Anna Craw
Cc: David Meates; Susan Fitzmaurice
Subject: Re: CDHB - Board Meeting - 18 June 2020 - Draft Agendas

Anna
There should be in public excluded a Primary Care Report from Carolyn and CCN.
John

Sent from my iPhone

> On 4/06/2020, at 14:12, Anna Craw <Anna.Craw@cdhb.health.nz> wrote:
>
>
> <image001.gif>

Kathleen Smitheram

From: John Hansen
Sent: Friday, 5 June 2020 11:41 AM
To: Anna Craw
Cc: David Meates; Susan Fitzmaurice
Subject: Re: CDHB - Board Meeting - 18 June 2020 - Draft Agendas

Anna/David
Just one other matter. It would be useful to the board if the Emerging Issues, in public excluded, is supported by a one page bullet point paper.
Thanks
John

Sent from my iPad

> On 4/06/2020, at 14:12, Anna Craw <Anna.Craw@cdhb.health.nz> wrote:
>
>

Kathleen Smitheram

From: John Hansen
Sent: Thursday, 18 June 2020 8:08 AM
To: David Meates
Subject: FW: Letter from Hon Dr David Clark
Attachments: To Sir John Hansen.pdf

David
I see you have been sent a copy of this letter. Over to management to do what you can.
John

From: Catherine Pearson <Catherine.Pearson@parliament.govt.nz>
Sent: Wednesday, 17 June 2020 5:04 PM
To: John Hansen <John.Hansen@cdhb.health.nz>
Cc: David Meates <David.Meates@cdhb.health.nz>
Subject: Letter from Hon Dr David Clark

Kia ora

Please find attached a letter to you from Hon Dr David Clark, Minister of Health.

Ngā mihi
Catherine

Catherine Pearson | **Private Secretary, Health**
Office of Hon Dr David Clark
Minister of Health

Hon Dr David Clark

MP for Dunedin North

Minister of Health

17 June 2020

Sir John Hansen
Board Chair
Canterbury District Health Board

Dear Sir John

I am writing to encourage your organisation to increase its uptake of subscriptions for New Zealand small to medium[1] news services in order to support organisations impacted by COVID-19.

As you will be aware, New Zealand's media sector has been severely impacted by the COVID-19 response due to a drastic drop in advertising revenue. At the same time, media has a vital role during the response period in ensuring ongoing access to reliable and up-to-date news coverage and keeping New Zealanders while COVID-19 restrictions are in place. Private media are critical in supporting the production of news and journalism and ensuring our democracy has a strong and independent fourth estate.

As part of the government's support package for the media sector, there has been an uptake of 12 month subscriptions or donations at an appropriate level across all government departments to New Zealand small to medium news organisations which produce quality journalism with a broad public interest component at a national level.

If Crown Entities were also to take out subscriptions it would assist by providing immediate revenue to New Zealand news services, to help them to continue to provide these valuable news services. It will also ensure your staff have access to a diversity of voices and perspectives which can inform their work.

It has also been brought to my attention that some organisations take out small subscriptions that are then shared widely across the organisation. I encourage you to look at the nature of subscription licensing that your entity currently holds to ensure that it appropriately reflects the number of users registered.

The Ministry for Culture and Heritage will release information shortly on its website about how this initiative will be implemented across central government. Please contact Support.Media@mch.govt.nz at the Ministry for Culture and Heritage if you have any questions about this proposal.

[1] The Government Procurement Rules define a New Zealand business as a business that originated in New Zealand (not being a New Zealand subsidiary of an offshore business), is majority owned or controlled by New Zealanders, and has its principal place of business in New Zealand. For the purpose of this initiative, a small to medium business employs up to 50 FTE staff members on a permanent basis

Kathleen Smitheram

From: John Hansen
Sent: Monday, 22 June 2020 11:11 AM
To: David Meates
Subject: Re: MEDIA ENQUIRY FW: Stuff: Clinical Leaders Group letter to the CDHB board[EXTERNAL SENDER]

Thanks. How does Rob not understand the funding required went to CIC and was rejected for whatever reason.

Sent from my iPhone

On 22/06/2020, at 11:05, David Meates <David.Meates@cdhb.health.nz> wrote:

John

I will work with Alex on a draft response that will run past you.

Ngā mihi

David Meates, MNZM
Chief Executive | Canterbury District Health Board and West Coast District Health Board
T: 03 364 4110 (ext 62110) | E: david.meates@cdhb.health.nz
P O Box 1600, Christchurch 8140
www.cdhb.health.nz | www.westcoastdhb.org.nz

<image001.jpg>
Values – Ā Mātou Uara
Care and respect for others - Manaaki me te whakaute i te tangata | Integrity in all we do - Hāpai i ā mātou mahi katoa i runga i te pono | Responsibility for outcomes - Te Takohanga i ngā hua

From: John Hansen
Sent: Monday, 22 June 2020 10:34 AM
To: Alex Taylor (Communications) <Alex.Taylor2@cdhb.health.nz>; David Meates <David.Meates@cdhb.health.nz>
Subject: Re: MEDIA ENQUIRY FW: Stuff: Clinical Leaders Group letter to the CDHB board[EXTERNAL SENDER]

It is not a simple matter of trying to address the questions. We need to properly set the scene. What we asked of CIC for the campus master plan. Unlike Rob's letter this clearly set out the funding needed. We did not get it.What we were offered. The background of the board's decision when the only proposal put forward for consideration close to the funding envelope was the one approved by the board. That it appears to be a view from some that we should not accept that funding without putting forward an alternative. That this meant the timing for the campus redevelopment did not meet what the board, management and clinicians had hoped for. As a consequence it become apparent the buildings needed to be used longer then intended. A group is looking at the implications of that urgently and The subsequent funding that would be required. Don't disagree with comments re facilities but (I am assuming this) a conscious decision appears to have been made not to spend money on these facilities (David I assume this is correct). Patient safety is of course the most important thing but we can't spend money we have not got. As an organisation we also need to live within our means and the funding we receive from taxpayers. The funding requested was clear but in the restrained capital environment many DHB's did not get what they

requested. We have to do our best with what we have especially in the light of our operating deficit. This can be prepared as a statement from me. I will not be doing an interview.
Call me if you need to.

Sent from my iPad

On 22/06/2020, at 09:39, Alex Taylor (Communications) <Alex.Taylor2@cdhb.health.nz> wrote:

Hi John and David,

See below enquiry 9(2)(a) has been given a copy of the letter sent by the Clinical Leaders Group to the Board.

As a consequence of this he has some questions he'd like us to address.

Upon reading these, my inclination is that qs 1 and 2 are best addressed by us from an operational perspective and qs 3-9 require a response from the Board Chair.

Let me know what you think and how you would like to respond – a phone interview might work for qs 3-9?

Cheers
Alex

Alex Taylor
Senior Media Advisor
Canterbury and West Coast District Health Boards
T: 03 364 4122 or ext: 62122 | M: 027 567 5343
Level 1, Corporate Office, 32 Oxford Terrace, Christchurch
<image002.jpg>

From: 9(2)(a)
Sent: Sunday, 21 June 2020 8:46 p.m.
To: Alex Taylor (Communications) <Alex.Taylor2@cdhb.health.nz>; Karalyn van Deursen <Karalyn.Vandeursen@cdhb.health.nz>; Communications <Communications@cdhb.health.nz>
Subject: Stuff: Clinical Leaders Group letter to the CDHB board[EXTERNAL SENDER]

Hi all,

I've got a copy of a letter sent from the Clinical Leaders Group to the CDHB board last week which sets out a number of issues with the Parkside/Riverside buildings, and which seems to criticise the board for not explicitly stating the funding they require to safely deliver patient care.

The letter says the following:

1) That the Parkside theatres were rated the worst in NZ in the National Asset Management Programme (NAMP), and that they represent "nearly half our capacity on the campus in the foreseeable future".

2) The NAMP rated the Riverside Ward facility as one of the worst in NZ, and Parkside only slightly better. "These facilities will represent almost half of our bed capacity post-Hagley occupation."

3) "In terms of amenity - with the exception of two wards - only 7 per cent of rooms meet basic isolation standards and have an ensuite toilet (the current MOH-accepted guidelines specify 21 ensuites for 28 patients)."

4) "There are no accessible showers in Parkside or Riverside wards; most toilets are only 970mm wide precluding safe handling of patients. Most wards have only 3 showers to 28 patients.

5) "We are the last major DHB to house 6 acute patients in one bedroom - which precludes appropriate separation and any practical use of hoists to move patients, in clear contravention of the DHB's 'no lifting' policy for staff."

6) The DHB has had 74 outbreaks of norovirus gastroenteritis over a five year period affecting 526 patients and more than 200 staff "in our older amenities" (someone has clarified for me that that means Christchurch Hospital). The nine new Burwood wards have had just six small outbreaks over four years. "These, and many other shortcomings, are clear indictments of our older facilities and should be red flags to our health and safety obligations to both patients and staff.

7) The clinicians then say "with the spectre of occupying these facilities for a further 15+years, it should be noted there is currently no identified request for funding for any clinical upgrade to these existing ward amenities or to these operating theatres in lieu of new amenities. There is also no identified funding path to meet our agreed capacity requirements.

8) They then seem to criticise the board. "I suggest the board has a responsibility to the people of Canterbury to be explicit about the appropriate requirements for funding in order to safely deliver the patient care that the ministry requires of it. In turn it is the ministry's responsibility to recommend a decision on funding allocation to the ministers, and to Treasury; being fully informed of the implications of any shortfall that might exist with its impact on the delivery of care. I urge the board to carefully consider the distinction."

I've also spoken to a senior medical figure who has strongly criticised the "hostile" board, saying they have been heedless of clinical advice, and that they are obsessed with balancing the books at the expense of providing safe facilities/capacity.

Questions below:

1) Re the number of gastro outbreaks. Is that in the past five years on the Chch Hospital campus? Does the CDHB have any comment on the number/cause of outbreaks.

2) How many operating theatres are in Parkside? Will they all continue to be in use once Hagley opens?

3) Does the CDHB have any comment re being the last major DHB to house six patients to a a room?

4) Has the board heard back re the $150m tower 3 development? Has it been approved?

5) Meates has previously said the CDHB will continue to occupy Riverside until at least 2025. What is the 15+ timeframe the clinicians are referring to?

6) Why has there been no request for funding to improve Parkside/Riverside? Has the CDHB done any planning on what needs to be done/how much it will cost?

7) The clinicians seem to have lost faith in the board. They say there is no identified funding path to meet capacity requirements. And they say "I suggest the board has a responsibility to the people of Canterbury to be explicit about the appropriate requirements for funding in order to safely deliver the patient care that the ministry requires of it." And that it's then the ministry's job to make the funding recommendation knowing the impact a lowball figure will have on patient care. Why did the board not advocate for tower 3 and 4, which the clinicians have said is the only way to meet capacity requirements?

8) Has the board lost the confidence of the clinicians?

9) Please feel free to address anything else in the letter.

I'm doing the story tomorrow. So please provide a response by 3pm. Let me know if a phone interview is easier, and please let me know when you get this.

Cheers.

9(2)(a)

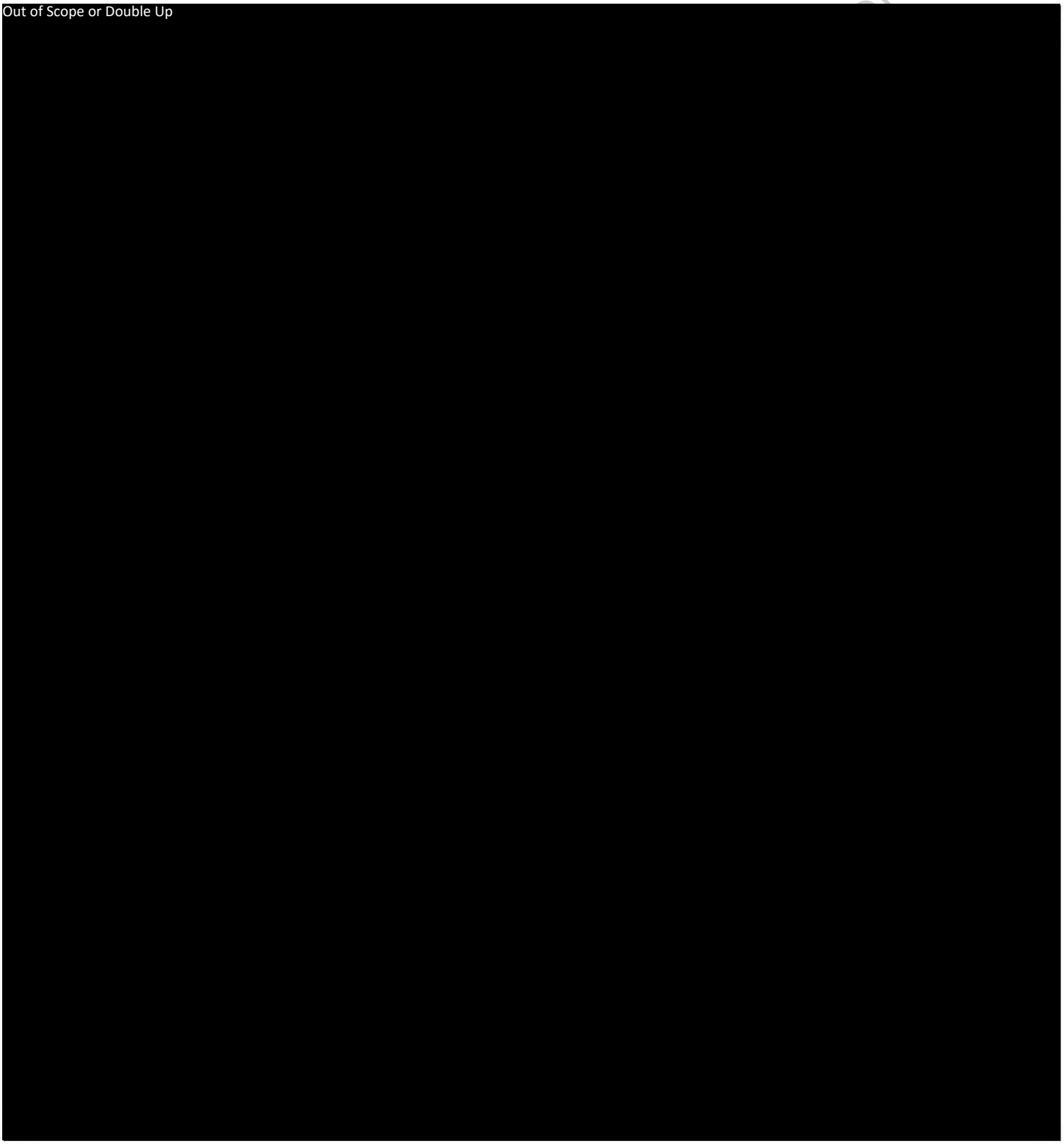
Kathleen Smitheram

From: John Hansen
Sent: Monday, 22 June 2020 11:26 AM
To: David Meates
Subject: Re: MEDIA ENQUIRY FW: Stuff: Clinical Leaders Group letter to the CDHB board[EXTERNAL SENDER]

David given references to CIC WC it'll need to go past MOH and minister's office

Sent from my iPhone

Out of Scope or Double Up



Kathleen Smitheram

From: John Hansen
Sent: Wednesday, 24 June 2020 8:32 AM
To: David Meates
Subject: Re: COVID Testing

Thanks. The cost issue is raised at every meeting

Sent from my iPad

On 23/06/2020, at 18:21, David Meates <David.Meates@cdhb.health.nz> wrote:

Over the past week the level of COVID testing has increased markedly in response to the border breech and the response from Govt that is driving significant increases in testing. Interesting to note that testing on under 15"s over the past three weeks is more in total than all the testing done on that age group since March.

The Minister has sent out a media release clarifying testing expectations which will see further increases.

Just to give a sense of the impact on this:

- Daily CBAC requirement has gone from 80 per day early last week to 491 referrals yesterday.
- Ques starting to form for testing.
- This does not include swabbing numbers from general practice – 80% general practice is swabbing also.
- General practice is starting to get overwhelmed with PPE requirements and impact of testing
- Currently this is now costing approx. $100k per day without surveillance or border staff testing
- 1,300 tests processed through lab today

Clarity has been provided from the MOH this evening that we need to continue and that this will go onto our bottom line and should just be added to the COVID tracker as there is no more funding available this financial year.

This is an issue being raised by a number of Chairs and I understand that this will be raised at the Chairs meeting with Minister later in the week.

Ngā mihi

David Meates, MNZM
Chief Executive | Canterbury District Health Board and West Coast District Health Board
T: 03 364 4110 (ext 62110) | E: david.meates@cdhb.health.nz
P O Box 1600, Christchurch 8140
www.cdhb.health.nz | www.westcoastdhb.org.nz

<image001.jpg>
Values – Ā Mātou Uara
Care and respect for others - Manaaki me te whakaute i te tangata | Integrity in all we do - Hāpai i ā mātou mahi katoa i runga i te pono | Responsibility for outcomes - Te Takohanga i ngā hua

Kathleen Smitheram

From: John Hansen
Sent: Sunday, 28 June 2020 3:07 PM
To: David Meates
Subject: Meaghan Woods

David
At the minister's request I met on Friday afternoon. She wanted to advise me that there would be 2 more isolation/quarantine hotels in Christchurch. Of course you had already briefed me on this. She did give me the names of the hotel. She was just ensuring the board would be supportive. I said we would of course be but it would be helpful to CDHB I'd international flights came direct etc etc (the concerns you had raised with me). She and the Wing Commander said they did all they can but that offer things like exact numbers were not known until the plane door shut. I accepted that but we should be able to get the general number that can be refined as soon as possible. She also raised car parking again so hopefully we can get that sorted at QFRAC.
I also should have mentioned that I briefed David Clark on Ernest Henshaw's research trust. He was very interested so I have arranged a meeting for late July.
John

Sent from my iPad

From: David Meates
To: John Hansen
Cc: Barry Bragg
Subject: Antigua Street PPP proposal - Paper
Date: Wednesday, 1 July 2020 7:19:00 PM
Attachments: Board Paper- Antigua Street PPP carparking proposal 30-06-18.docx
120921-35 (1997317-1) CDHB hospital car park - 29 June.docx
image001.jpg

John

As requested, please find **attached** a Paper for Board consideration and direction regarding the land out PPP.

I've also **attached** the Heads of Agreement being negotiated between Otakaro, CDHB, LINZ and 9(2)(a) by Tim Lester (Appendix 2 to the paper- Tim's comments shown). In the interest of time, ideally we get approval of *the form* of HoA at the same time, so that we can finalise and sign without bringing it back to the Board. I don't see any issues in reaching agreement with the parties on the HoA. It will go through usual CDHB sign-off (as well as Ministerial signoff given it commits us to dispose of the ASC and enter into a co-operative arrangement with Otakaro/LINZ/9(2)(a)).

Could you review the attached Board paper and advise

Nga mihi

David Meates, MNZM
Chief Executive | Canterbury District Health Board and West Coast District Health Board
T: 03 364 4110 (ext 62110) | E: david.meates@cdhb.health.nz
P O Box 1600, Christchurch 8140
www.cdhb.health.nz | www.westcoastdhb.org.nz

Values – A Matou Uara
Care and respect for others - Manaaki me te whakaute i te tangata | Integrity in all we do - Hapai i a matou mahi katoa i runga i te pono | Responsibility for outcomes - Te Takohanga i nga hua

Kathleen Smitheram

From: John Hansen
Sent: Monday, 3 August 2020 1:45 PM
To: David Meates
Subject: Re: Resignation of Carolyn Gullery - Executive Director Planning, Funding and Decision Support

Thanks David. Very appropriate

Sent from my iPhone

On 3/08/2020, at 12:43, David Meates <David.Meates@cdhb.health.nz> wrote:

John – below is an email that I will be sending out to the organisation shortly re Carolyn Gullery. Need to get this out as her decision to resign is starting to become visible

It is with regret I advise that Carolyn Gullery resigned from her role as Executive Director Planning, Funding and Decision Support for both the Canterbury and West Coast Health Systems. Carolyn will be moving to the in September to work with Lightfoot Solutions supporting a number of NHS systems in Wales and England .

Since joining Canterbury District Health Board as Planning and Funding General Manager in 2007, Carolyn has played a significant part in reshaping the way health care is delivered in both Canterbury and the West Coast.

Carolyn has had more than thirty years of health system experience in a variety of strategic and leadership roles for both public and private sector. She has extensive experience in leading complex planning and change processes at a regional and national level together with a proven track record of successfully negotiating health and disability sector contracts at all levels.

Carolyn's career is littered with a number of 'firsts'. Her ability to 'see around corners' and identify solutions that others haven't considered has combined well with her extensive health policy and health alliancing and contracting experience to get a complex health system on track and keep it there.

Carolyn has worked for the CDHB for 13 years but her contribution to the health system in Canterbury, West Coast and New Zealand goes back much further than that. Carolyn came to Canterbury in 1993 to be part of the establishment of the Southern Regional Health Authority. In her time in the various versions of the Health Authorities amongst other things she designed and negotiated the first IPA contract with Pegasus , set up the first budget holding contracts for laboratory and pharmacy services in New Zealand, changed how we received medication to repeat dispensing saving the country $60M in the first year, and led the development of key policies and strategies that impacted on pharmaceuticals, pharmacy and general practice including the development of BPAC and the PharmHouse. She was also the first female and first non-RHA Chief Executive to becomes a Director of PHARMAC in 1997.

As a contractor during the 2000s, she was on the negotiating team for the new PHO agreement (the general practice side) , wrote the policy and implemented CarePlus as an innovative approach for people with complex health and social challenges, operationalised restorative home support in the North Island and was the founding Chief Executive for the largest single PHO , Partnership health . What we have all benefited from though was her leadership with her clinical colleagues in developing the world - first general practice-led acute admission avoidance programme – 20 years ago and still seen as innovative today. That programme is still with us as the Acute Demand Management Service looking after 35,000 people per annum in a community-based setting and anchoring so much of what we do. That programme was built on trust which set the scene for the development of an integrated adaptive health system based on trust and the alliancing approach.

Carolyn has been instrumental in the development of platforms that support clinicians to do their work including ERMS, HealthPathways, Leading Lights, our Outcomes Framework, the earthquake recovery plan, many hospital business cases , Vision 2020 and the elements to support a truly people-centered health system.

On behalf of the Board and EMT, I acknowledge Carolyn's tremendous contribution to both the Canterbury and West Coast Health Systems and wish her every success for her new role.

Ngā mihi

David Meates, MNZM
Chief Executive | Canterbury District Health Board and West Coast District Health Board
T: 03 364 4110 (ext 62110) | E: david.meates@cdhb.health.nz
P O Box 1600, Christchurch 8140
www.cdhb.health.nz | www.westcoastdhb.org.nz

<image001.jpg>
Values – Ā Mātou Uara
Care and respect for others - Manaaki me te whakaute i te tangata | Integrity in all we do - Hāpai i ā mātou mahi katoa i runga i te pono | Responsibility for outcomes - Te Takohanga i ngā hua

Kathleen Smitheram

From: John Hansen
Sent: Wednesday, 5 August 2020 10:09 AM
To: David Meates
Cc: Barry Bragg
Subject: Re: Resignation

That would be helpful

Sent from my iPad

On 5/08/2020, at 08:54, David Meates <David.Meates@cdhb.health.nz> wrote:

Absolutely. Will get a framework together so that you can agree some choices if that would help

David Meates MNZM
CEO Canterbury and West Coast DHBs

On 5/08/2020, at 8:13 AM, John Hansen <John.Hansen@cdhb.health.nz> wrote:

I think we need to meet to get an understanding of the strength of the 2s and 3s etc in organisation as the board have little visibility of these people.
I'm in Wellington today and tomorrow.
John

Sent from my iPhone

On 5/08/2020, at 07:57, David Meates <David.Meates@cdhb.health.nz> wrote:

John / Barry

Have just received Justines resignation this morning. I will work on a range of acting roles during today as it will be really important that that we get the organisation settled as soon as possible.

David Meates MNZM
CEO Canterbury and West Coast DHBs

9(2)(a)

[redacted]

Kathleen Smitheram

From: John Hansen
Sent: Wednesday, 5 August 2020 8:13 AM
To: David Meates
Cc: Barry Bragg
Subject: Re: Resignation

I think we need to meet to get an understanding of the strength of the 2s and 3s etc in organisation as the board have little visibility of these people.
I'm in Wellington today and tomorrow.
John

Sent from my iPhone

On 5/08/2020, at 07:57, David Meates <David.Meates@cdhb.health.nz> wrote:

John / Barry

Have just received Justines resignation this morning. I will work on a range of acting roles during today as it will be really important that that we get the organisation settled as soon as possible.

David Meates MNZM
CEO Canterbury and West Coast DHBs

Begin forwarded message:

9(2)(a)

[redacted]

Kathleen Smitheram

From: John Hansen
Sent: Wednesday, 5 August 2020 2:34 PM
To: David Meates
Subject: Re: Resignation of Justine White, Chief Financial Officer

David when were you advised of this. She is only giving 3 and a half weeks notice.

Sent from my iPad

On 5/08/2020, at 12:17, David Meates <David.Meates@cdhb.health.nz> wrote:

Kia ora koutou

It is with regret I advise that Justine White has resigned from her role as Chief Financial Officer and Executive Director of Finance and Corporate Services, Canterbury DHB and West Coast DHB.

Justine came to health 9 years ago after a career in the private sector. She has been a central member of the Executive Team that has navigated the Canterbury Health System through its most challenging period, and a key leader in the transformation of health services on the West Coast.

Justine has led the implementation of new finance and procurement systems. She has successfully driven large scale change, including the in-sourcing of food and cleaning services that have driven millions of dollars of efficiencies and enabled more care within constrained resources. She led the settlement of one of New Zealand's largest ever insurance payments following the Canterbury earthquakes. She has also played an essential role in Canterbury's facility repair and construction programme, which is the largest ever capital development programme in the history of New Zealand's public health system.

Justine has also provided leadership nationally. Since 2012, she has chaired the 20 DHB Chief Financial Officers group, a role which she continues today. She has led the redesign of the insurance programme for all 20 DHBs, and she is currently a central contributor to the implementation of the national finance and procurement system across the sector.

I have worked with many Chief Financial Officers in my career. Justine is without doubt an absolutely gifted CFO and a talented strategist and leader. She has made a hugely positive difference to health services in Canterbury and on the West Coast, and I wish her every success for the future.

Justine is leaving to take up the role of Chief Financial Officer for the Auckland District Health Board. In a statement released in Auckland this morning by Ailsa Claire - CEO, she says "Auckland DHB is thrilled to have attracted a Chief Financial Officer of Justine's calibre, and we look forward to welcoming her soon."

Justine's last working day is Friday 28 August 2020.

Ngā mihi

David Meates, MNZM
Chief Executive | Canterbury District Health Board and West Coast District Health Board

T: 03 364 4110 (ext 62110) | E: david.meates@cdhb.health.nz
P O Box 1600, Christchurch 8140
www.cdhb.health.nz | www.westcoastdhb.org.nz

Values – Ā Mātou Uara
Care and respect for others - Manaaki me te whakaute i te tangata | Integrity in all we do - Hāpai i ā mātou mahi katoa i runga i te pono | Responsibility for outcomes - Te Takohanga i ngā hua

Kathleen Smitheram

From: John Hansen
Sent: Wednesday, 5 August 2020 8:35 PM
To: David Meates
Subject: Re: Resignation of Justine White, Chief Financial Officer

Thanks

Sent from my iPhone

On 5/08/2020, at 16:46, David Meates <David.Meates@cdhb.health.nz> wrote:

John

I was advised of Justine's resignation this morning. I understand that she had an interview with ADHB last Friday.

Justine has a 9(2)(a) contractual notice period in her employment agreement 9(2)(a) 9(2)(a) 9(2)(a) I have agreed with Justine that she will continue to work until 28 August at which point her employment will end. I am also mindful that Justine has accepted the role of CFO at Auckland DHB who we have a close relationship and therefore I do not believe it is in our best interests to stand in the way of her and ADHB's desire for her to commence as soon as possible. This will also ensure her ability to support anyone that is in the acting which is part of managing risk.

Ngā mihi

David Meates, MNZM
Chief Executive | Canterbury District Health Board and West Coast District Health Board
T: 03 364 4110 (ext 62110) | E: david.meates@cdhb.health.nz
P O Box 1600, Christchurch 8140
www.cdhb.health.nz | www.westcoastdhb.org.nz

<image001.jpg>
Values – Ā Mātou Uara
Care and respect for others - Manaaki me te whakaute i te tangata | Integrity in all we do - Hāpai i ā mātou mahi katoa i runga i te pono | Responsibility for outcomes - Te Takohanga i ngā hua

Out of Scope or Double Up

Kathleen Smitheram

From: David Meates
Sent: Thursday, 6 August 2020 9:43 AM
To: John Hansen
Cc: Barry Bragg
Subject: Re: Interim Options (for discussion)

I am on the Coast Friday for Board meeting. Can do first thing next week

Sent from my iPad

> On 6/08/2020, at 9:38 AM, John Hansen <John.Hansen@cdhb.health.nz> wrote:
>
> Thank you for that David. Barry I think we should meet with David regarding this to discuss. I think we need to have Gabrielle and Lester join us. I can do mid morning tomorrow if that works.
> John
>
> Sent from my iPad
>
>> On 6/08/2020, at 09:22, David Meates <David.Meates@cdhb.health.nz> wrote:
>>
>> John / Barry
>>
>> With all the changes going on, it is really important that we are able to provide certainty going forward for both the DHB (Canterbury and West Coast) as well as the broader health system.
>>
>> There are several underlying drivers / factors:
>> 1: Finance, Planning and Funding and People and Capability functions are all pivotal to deliver the savings plan. As we have discussed, the $56M plan is a credible plan that can be delivered provided that it remains front and centre stage.
>> 2: Need for continuity. Would propose secondments for 6 months with opportunity to extend. Anything shorter runs the risk of de-stabilising continuity.
>> 3: Recruitment process for the executive roles is likely to take at least 3-6 months.
>> 4: Impact of COVID-19 on potential recruitment options from overseas.
>>
>> INTERIM ARRANGEMENTS
>> The three key areas requiring interim arrangements include Planning and Funding, Finance, and People and Capability.
>>
>> Below is an outline of what interim internal secondment arrangements could go into place. This would require you to be happy with the approach. At this point, the only conversation that has been had is with Paul Lamb as Michael resigned some weeks ago and he is well down the track with handover arrangements.
>>
>> Acting Executive Director Planning and Funding: Second two individuals - Melissa Macfarlane (for core planning and funding functions) and Ralph La salle (for contracts, production planning and service provision). As part of the agreement with Carolyn Gullery, she would continue to provide support to the team and support for the PMO (programme office) until end October.
>>
>> Acting Chief Financial Officer: Second David Green. Wei in the finance team provides great support for David. Wei is a previous CFO at the DHB. Justine is happy to provide support for David if he was to step into role.
>>
>> Acting Chief People Officer: Second Paul Lamb. Paul is currently leading the change program as part of the PMO. Michael is happy to provide support / advice for Paul if required.

>>
>> Dan Coward (as operational General Manager) has already been seconded to lead the PMO office including the weekly reporting of progress re savings plans that will be commencing next week - the first weekly template is with me at the moment which just requires a few tweaks.
>>
>> The other really critical area is delivering on the Hagley migration. This is the largest and most complex migration ever undertaken in NZ. Mary Gordon is critical to this process of delivering.
>>
>> EXECUTIVE SEARCH FOR PERMANENT REPLACEMENTS As highlighted
>> previously, the search process for the Chief People Officer with Kerridge and Partners is well underway. We engaged Kerridge because they have undertaken a range of executive search asssignments in health, including the recent CEO searches for Waikato and Counties Manukau DHBs. They also undertake a range of search assignments in the private sector. We had engaged Kerridge prior to the resignations of Carolyn and Justine.
>>
>> I would suggest that you think about a search process for the three roles using Kerridge & Partners.
>>
>> Happy to discuss.
>>
>> Sent from my iPad

Kathleen Smitheram

From: David Meates
Sent: Thursday, 6 August 2020 12:55 PM
To: John Hansen
Cc: Barry Bragg; Lester Levy; Gabrielle Huria
Subject: Re: Interim Options (for discussion)

Could do zoom meeting 8 am Monday

David Meates MNZM
CEO Canterbury and West Coast DHBs

> On 6/08/2020, at 12:53 PM, John Hansen <John.Hansen@cdhb.health.nz> wrote:
>
> Given David's WC commitment tomorrow can I suggest a Zoom meeting 8 am Monday morning if everyone is available.
> John
>

Out of Scope or Double Up

[redacted]

Kathleen Smitheram

From: David Meates
Sent: Monday, 10 August 2020 10:34 AM
To: John Hansen
Subject: Re: Contact Details

Have had a quick chat with David and Paul. Carolyn having a chat with Melissa (Ralph on leave)

Sent from my iPad

> On 10/08/2020, at 10:16 AM, John Hansen <John.Hansen@cdhb.health.nz> wrote:
>
> Thanks. Have you spoken to them yet?
>
> Sent from my iPhone
>
>> On 10/08/2020, at 10:11, David Meates <David.Meates@cdhb.health.nz> wrote:
>>
>> John / Barry
>>
>> Contact details as requested
>>
>> Melissa Macfarlane 9(2)(a) [redacted]
>> Ralph La salle 9(2)(a) [redacted]
>> Paul Lamb 9(2)(a) [redacted]
>> David Green (9(2)(a) [redacted]
>>
>> David

Kathleen Smitheram

From: David Meates
Sent: Monday, 10 August 2020 7:03 PM
To: John Hansen
Subject: RE: Contact Details

John

Some key points in determining allowance arrangements (which are paid in addition to the substantive salary for the period of acting up):

1. Those acting up will be taking on all of the core responsibilities of the role.
2. There is a level of uncertainty as to how long someone will be acting up; Presumably it could be anywhere from 3 months to 9 months in a worst case scenario.

9(2)(a) [redacted]

David Meates, MNZM
Chief Executive | Canterbury District Health Board and West Coast District Health Board
T: 03 364 4110 (ext 62110) | E: david.meates@cdhb.health.nz P O Box 1600, Christchurch 8140 www.cdhb.health.nz | www.westcoastdhb.org.nz

Values – Ā Mātou Uara
Care and respect for others - Manaaki me te whakaute i te tangata | Integrity in all we do - Hāpai i ā mātou mahi katoa i runga i te pono | Responsibility for outcomes - Te Takohanga i ngā hua

Out of Scope or Double Up [redacted]

Kathleen Smitheram

From: David Meates
Sent: Monday, 10 August 2020 3:26 PM
To: John Hansen
Subject: Succession planning Summary for Neurosurgery SMOs
Attachments: Neurosurgery succession planning final.docx; ATT00001.htm

John

Attached is the Neurosurgery SMO succession plan that requires a commitment to employ/ advert, to show we are interested and get some commitment 9(2)(a) [redacted] that the service are trying to recruit. 9(2)(a) [redacted]
9(2)(a) [redacted]

Effectively we have 2-3 retirements pending in next 3-5 years and ongoing vulnerabilities with the Southern DHB re Neurosurgeons. This is a critical process to get underway to ensure that we sustain a viable neurosurgical service.

Further to your note today, I had given verbal approval to progress this some weeks ago but need to be comfortable that you are ok with this decision.

Ngā mihi

David Meates, MNZM
Chief Executive | Canterbury District Health Board and West Coast District Health Board
T: 03 364 4110 (ext 62110) | E: david.meates@cdhb.health.nz
P O Box 1600, Christchurch 8140
www.cdhb.health.nz | www.westcoastdhb.org.nz

make it better

Values – Ā Mātou Uara
Care and respect for others - Manaaki me te whakaute i te tangata | Integrity in all we do - Hāpai i ā mātou mahi katoa i runga i te pono | Responsibility for outcomes - Te Takohanga i ngā hua

Kathleen Smitheram

APPENDIX 2

From: Lester Levy 9(2)(a)
Sent: Monday, 27 July 2020 12:13 PM
To: David Meates
Cc: John Hansen; Barry Bragg; Susan Fitzmaurice
Subject: Re: Final Draft Canterbury DHB Annual Plan 2020/21

Thanks David

From: David Meates <David.Meates@cdhb.health.nz>
Sent: Monday, 27 July 2020 12:04 PM
To: Lester Levy 9(2)(a)
Cc: John Hansen <John.Hansen@cdhb.health.nz>; Barry Bragg <barry@bclimited.co.nz>; Susan Fitzmaurice <Susan.Fitzmaurice@cdhb.health.nz>
Subject: FW: Final Draft Canterbury DHB Annual Plan 2020/21

Lester

Pls find attached the current version – this is the one most recently submitted and includes the updated performance measure changes requested by the Ministry this morning (as per the email below).

Ngā mihi

David Meates, MNZM
Chief Executive | Canterbury District Health Board and West Coast District Health Board
T: 03 364 4110 (ext 62110) | E: david.meates@cdhb.health.nz
P O Box 1600, Christchurch 8140
www.cdhb.health.nz | www.westcoastdhb.org.nz

[redacted]

Values – Ā Mātou Uara
Care and respect for others - Manaaki me te whakaute i te tangata | Integrity in all we do - Hāpai i ā mātou mahi katoa i runga i te pono | Responsibility for outcomes - Te Takohanga i ngā hua

---

From: Lester Levy 9(2)(a)
Sent: Monday, 27 July 2020 11:33 AM
To: David Meates <David.Meates@cdhb.health.nz>; John Hansen <John.Hansen@cdhb.health.nz>; Barry Bragg 9(2)(a)
Cc: Susan Fitzmaurice <Susan.Fitzmaurice@cdhb.health.nz>
Subject: Re: Final Draft Canterbury DHB Annual Plan 2020/21

Thanks David

Can I please receive a copy of the most recent draft annual plan sent through to the MoH.

Many thanks

Lester

From: David Meates <David.Meates@cdhb.health.nz>
Sent: Monday, 27 July 2020 11:24 AM

To: John Hansen <John.Hansen@cdhb.health.nz>; Barry Bragg <9(2)(a)> Lester Levy 9(2)(a)

Cc: Susan Fitzmaurice <Susan.Fitzmaurice@cdhb.health.nz>
Subject: FW: Final Draft Canterbury DHB Annual Plan 2020/21

Please find attached and email below the feedback received from the MOH this morning re Annual Plan.

Ngā mihi

David Meates, MNZM
Chief Executive | Canterbury District Health Board and West Coast District Health Board
T: 03 364 4110 (ext 62110) | E: david.meates@cdhb.health.nz
P O Box 1600, Christchurch 8140
www.cdhb.health.nz | **MailScanner has detected a possible fraud attempt from "urldefense.com" claiming to be**
www.westcoastdhb.org.nz

[redacted]

Values – Ā Mātou Uara
Care and respect for others - Manaaki me te whakaute i te tangata | Integrity in all we do - Hāpai i ā mātou mahi katoa i runga i te pono | Responsibility for outcomes - Te Takohanga i ngā hua

From: Krysta.George@health.govt.nz <Krysta.George@health.govt.nz> **On Behalf Of** AnnualPlan@health.govt.nz
Sent: Monday, 27 July 2020 9:23 a.m.
To: Carolyn Gullery <Carolyn.Gullery@cdhb.health.nz>; Melissa Macfarlane <Melissa.Macfarlane@cdhb.health.nz>; Sarah Ioannou (nee Greig) <Sarah.Ioannou@cdhb.health.nz>
Cc: Michelle.Arrowsmith@health.govt.nz; Justine White <Justine.White@cdhb.health.nz>
Subject: Final Draft Canterbury DHB Annual Plan 2020/21

Good morning,

Many thanks for sending through your Final Draft Annual Plan.

Please find some minor feedback below that needs to be addressed before the final submission of your plan. Please resolve this feedback and progress to Board sign out of your Annual Plan. The Ministry will do final checks once the final signed version is received, please do not send the updated sections through.

Please send your Board signed plan to AnnualPlan@health.govt.nz as soon as your Board has approved your plan. Just a reminder that when your financial position is agreed the financial statements incorporated into the Board signed plan will be checked against the financial templates submitted to the Ministry, therefore please ensure that the numbers align. Also please speak with your CFO to ensure the financial templates provided to the Ministry accurately reflect the monthly phasing planned. If in doubt have a discussion with your financial adviser.

As your Statement of Performance Expectations (SPE) is incorporated into your final Annual Plan, please check that the cover of your Annual Plan meets the formatting requirements for the SPE. Information can be found on the NSFL via the link.
MailScanner has detected a possible fraud attempt from "urldefense.com" claiming to be
https://nsfl.health.govt.nz/accountability/annual-reports/parliamentary-paper-shoulder-numbers

A reminder that your Statement of Performance Expectations needs to be published on your DHB website by 15 August.

Priority area	Approval after final draft	Comments
2.2.2 Savings plans - in-year gains	Approved (technical issues)	Your relationship manager will be in contact to discuss
2.2.3 Savings plans - out year gains	Approved (technical issues)	Your relationship manager will be in contact to discuss
3.1.2 Service change	Approved (technical issues)	As acknowledged in the Minister's approval letter, no services char annual plan. Regarding identification of FTE changes, your relations shortly to confirm if any further updates are required to your annu
5.1.1 Performance measures	TBC	Feedback attached.

Please let us know if you have any queries.

Liz Stirling
Manager DHB Planning and Accountability

DHB Planning, Funding & Accountability
DHB Performance Support & Infrastructure
Ministry of Health
9(2)(a)
mailto:liz.stirling@health.govt.nz

APPENDIX 3

Kathleen Smitheram

From: David Meates
Sent: Tuesday, 23 June 2020 3:06 PM
To: Michelle.Arrowsmith@health.govt.nz
Subject: Annual Plan

Kia ora Michelle

I recognise that we have all been distracted by the impacts of COVID 19 and I know that your team has been really busy keeping the country coordinated which I am sure is why there was no discussion about the Minister rejecting our plan and no opportunity to work with you to avoid that outcome.

It is disappointing for my team given the effort that was applied to meet the EY recommendations in providing the Annual Plan financials. We were pleased to be able to improve on the original Plan financial outturn despite COVID 19 and the on-going delay of Hagley but that loses its impact when we have an unsigned Annual Plan .

I hope in this round we can have more direct feed-back which would allow the Team to adjust to meet the Minister's requirements

Ngā mihi

David Meates, MNZM
Chief Executive | Canterbury District Health Board and West Coast District Health Board
T: 03 364 4110 (ext 62110) | E: david.meates@cdhb.health.nz
P O Box 1600, Christchurch 8140
www.cdhb.health.nz | www.westcoastdhb.org.nz

make it better

Values – Ā Mātou Uara
Care and respect for others - Manaaki me te whakaute i te tangata | Integrity in all we do - Hāpai i ā mātou mahi katoa i runga i te pono | Responsibility for outcomes - Te Takohanga i ngā hua

Kathleen Smitheram

From: Michelle.Arrowsmith@health.govt.nz
Sent: Tuesday, 16 June 2020 4:45 PM
To: David Meates; John Hansen
Cc: Lester Levy
Subject: CDHB Master Plan Compliance Works Package[EXTERNAL SENDER]

Kia Ora David

Thanks for the opportunity for Karl to join the discussion on 28 May. Given you are all meeting tomorrow I thought it would be prudent to provide you the MoH view and our expectations of the meeting tomorrow. Apologies for the delay in getting this to you.

We appreciate you sharing your notes of the meeting of 28 May David. Taking onboard the focus of the discussion, Karl took a slightly different view of the meeting from your notes and I summarise his main points and next steps for progression below as;

- compliance issues are required in addition to Tower 3
- CDHB has $21m of remaining Earthquake Funds to contribute to compliance of health and safety issues
- the minimal compliance issues to be considered include structural panel repairs, passive fire compliance, and seismic upgrade (where needed for post earthquake functionality)
- it is noted many of the areas in the older buildings rate poorly for clinical fitness-for-purpose (6 bedded ward rooms, bed to shower/toilet ratio, etc)
- there is a need to be realistic about the post-Covid environment and the likely availability of capital for the Christchurch campus and the timeframes (likely to be lengthened)
- in that context the DHB Board, management, MOH, consultants and compliance agencies (CCC) will need to be open to a full consideration of any other solutions that may address capacity issues in a post Covid environment, including clinical and operating models and possible different capacity utilisation across the CDHB facilities
- the CDHB Board, management, MOH and consultants are to develop a range of alternative scenarios based on existing facilities continuing to be used over the next 5/10/15 year timelines. These scenario's are to highlight impacts /requirements on compliance and health and safety.

For tomorrow's workshop we have asked Sir John your Board Chair to chair the meeting for us all and the Ministry will support the facilitation of this workshop. We appreciate your agenda and thanks for circulating to everyone.

To be able to achieve our collective desired outcome of a defined minimal compliance package to compliment Tower 3 we will need to step back to the core issues and look beyond the solutions that have to date been developed through the masterplan (understanding the current capital context). It will be important to expedite this work to ensure a plan for both compliance and Tower 3 can be provided to CIC as soon as possible. The longer this takes the higher the risk in a constrained capital and fiscal environment. I urge you and the rest of the wider team to drive this work forward in a timely way.

In addition to this there is the matter of your place holder of $5m as part of the wider Health $300m package announced by Government. I understand that you had suggested to the HIU team that this be used for fit out of maternity and endoscopy units, however I understand these are leased properties and this isn't MoH normal process to approve this in a building not Crown owned. We would appreciate a discussion and view of alternates that would fit with this place holder funding for CDHB. Again we really need to expedite this process as part of responding to the Governments funding package. I am hoping you may have chance to discuss tomorrow and if not could I ask that you progress a conversation with the investment management team before the end of the week on this matter. I suggest you contact Jo Strachan-Hope in the first instance.

No doubt you and the DHB team have continued further thinking or work on the compliance plan since the meeting in May and I look forward to hear about the discussion and an agreed solution following tomorrows meeting.

Ngā mihi
Michelle

Michelle Arrowsmith
Deputy Director-General
DHB Performance Support & Infrastructure

Ministry of Health
Mobile: 9(2)(a) [redacted]
****

****

From: Helene.Carbonatto@health.govt.nz
To: 9(2)(a) ; David Meates; Sue Nightingale; Deborah.Woodley@health.govt.nz
Cc: Suz.Halligan@health.govt.nz
Subject: Facilities operating model [EXTERNAL SENDER]
Date: Wednesday, 3 June 2020 5:24:00 PM
Attachments: ATT00001.gif

Hi all
I'd like to convene an urgent discussion tomorrow re the operating model for managed facilities in Christchurch as discussed. David/Sue are you free at all tomorrow either at 9.30-10 or alternatively anytime between 12-1.30 for 30 minutes?
Nga mihi

Helene Carbonatto - Group Manager
COVID 19 Public Health Response
Ministry of Health I DHB Population Health and Prevention
Ministry of Health I Email: Helene.Carbonatto@health.govt.nz I Ph: 9(2)(a)
[redacted]
http://www.health.govt.nz

From: Michelle.Arrowsmith@health.govt.nz
To: Karl.Wilkinson@health.govt.nz; David Meates; Anna McMartin; Kirsty.Doig@health.govt.nz
Cc: 9(2)(a) "Clayton Cosgrove"
Subject: Fw: Grey PR - going in the morning
Date: Friday, 12 June 2020 11:30:10 AM

Dear All

This PR has been instigated as I understand from the DHB.

This PR requires DHB, MoH and Minister office sign out and approval before any PR is sent. This is normal practice for all capital infrastructure PRs.

At this stage I have not approved the PR from MoH and so no release should occur until all parties have agreed and approved.

There is also a requirement to discuss with all parties as to who is the lead in any PR, this could be DHB, MoH or Minister.

Any PR should be done jointly between DHB and MoH if they either party are the lead in the PR.

Nga mihi
Michelle

Michelle Arrowsmith
Deputy Director-General
DHB Performance Support & Infrastructure
Ministry of Health
Mobile: 9(2)(a)

----- Forwarded by Michelle Arrowsmith/MOH on 12/06/2020 11:24 a.m. -----

From: Michelle Arrowsmith/MOH
To: Kirsty Doig/MOH@MOH,
Cc: Karl Wilkinson/MOH@MOH
Date: 11/06/2020 11:09 p.m.
Subject: Re: Grey PR - going in the morning

We need to discuss this

The dates and figures in this press release do not match that of the OIA I have for sign out

Not approved until I'm assured of the dates and figures in both

Michelle Arrowsmith
Deputy Director General
DHB Performance Support and Infrastructure

Sent from my iPhone

On 11/06/2020, at 6:35 PM, Kirsty Doig <Kirsty.Doig@health.govt.nz> wrote:

Hi Michelle

Heads up on the PR below which the DHB wants to put out in the morning to meet the local paper's deadline (I wasn't aware until today the comms needed to go so soon but staff have now been told).

I've flagged it to the Minister's office & they're going to provide a quote from the Minister.

I discussed with Karl the increased $. There is an OIA on this anyway so thinking this is a good opportunity to get it out there. If asked we'll say the increase is due to ongoing delays, construction works and the settlement with Fletchers (that way it's not as clear how much Fletchers received).

Thanks, Kirsty

Dates for move into Te Nikau, Grey Hospital and Health Centre confirmed

Timings have been confirmed for the handover and move into Te Nikau, Grey Hospital and Health Centre.

West Coast DHB Chief Executive David Meates said he is thrilled to be able to announce that staff will start moving into the new facility on Thursday, 23 July 2020. The move will continue over the following 10 days through to Saturday, 1 August 2020.

“At this stage, we expect the first patients will be seen in the new facility from Wednesday 29 July. There is still some construction work to complete before we move in, and that’s on track,” he said.

The project has been led by the Ministry of Health, with Fletcher Construction, the main contractor. Health Infrastructure Director, Karl Wilkinson says it’s fantastic to get to the final stage.

“Everyone involved has been working extremely hard to get this new $121.9 million hospital finished so the West Coast community can benefit from this great facility. We expect to handover the building to the DHB around 20 July 2020.

“This new 8,500 square metre facility adjacent to the current Grey Base Hospital, includes 56 in-patient beds, three operating theatres and an integrated family health centre to support the delivery of primary care services.

“It also houses a 24/7 emergency department, critical care unit, acute and planned medical and surgical services, maternity services and outpatient care.

“Thanks to all those involved in the project, from the early design stages through to the current final preparations for opening this state-of-the-art facility, which will support new models of care on the Coast.”

David Meates said there will be regular updates to the community over the coming weeks as the DHB counts down to the move-in date.

“Over the next 5-6 weeks teams throughout the Grey Base Hospital campus will be busy installing equipment, stocking consumables and clinical supplies, clinical cleaning and installing and testing new information services infrastructure. Staff orientation and training will also start later this month.

“This is so much more than a new building, it heralds the start of some new ways of working on the West Coast. The design of this facility has been future-proofed to allow for flexible ways of working.

“We will be providing regular updates to the community so people know what’s happening when and where they will need to go for healthcare in the new facility,” David Meates said.

Kirsty Doig
Principal Communications Advisor
Ministry of Health
9(2)(a) [redacted]
kirsty.doig@health.govt.nz
www.health.govt.nz
****

From: Helene.Carbonatto@health.govt.nz
To: David Meates; Sue Nightingale
Subject: Fw: Letter CDHB Stand Up Christchurch Isolation Facilities [unclassified][EXTERNAL SENDER]
Date: Thursday, 4 June 2020 5:53:40 PM
Attachments: ATT00001.gif
ATT00002.gif

Hi both
Please see 9(2)(a) proposed changes below. Please let me know if these work for you both.
Many thanks
Nga mihi

Helene Carbonatto - Group Manager
COVID 19 Public Health Response
Ministry of Health I DHB Population Health and Prevention
Ministry of Health I Email: Helene.Carbonatto@health.govt.nz I Ph: 9(2)(a)
[redacted]

http://www.health.govt.nz

----- Forwarded by Helene Carbonatto/MOH on 04/06/2020 05:52 pm -----

From: 9(2)(a)@NZDF.mil.nz>
To: "'Helene.Carbonatto@health.govt.nz'" <Helene.Carbonatto@health.govt.nz>
Date: 04/06/2020 04:21 pm
Subject: RE: Letter CDHB Stand Up Christchurch Isolation Facilities [unclassified]

Helene,

Think this para is the key, but it might still contain ambiguity regarding roles/responsibilities. Could I suggest a few minor additions.

As discussed today, the operating model for this service will see Canterbury DHB take the health leadership function across facilities, which includes provision and commissioning of services into the facilities as well as the clinical governance for these services. The Regional Isolation and Quarantine (RIQ) coordination cell will be stood up to facilitate the central flow of information from Christchurch to the National Crisis Management Centre in Wellington. The RIQ will manage the facilities and logistics component of the operation and they will be ultimately accountable to the Isolation, Quarantine and Repatriation team in the National Crisis Management Centre. Clearly both health and RIQ will need to work closely together to be clear of each other's roles and accountabilities and resolve key issues as they arise.

AIRCDRE 9(2)(a)
SRO – Isolation, Quarantine and Repatriation workstream
COVID -19 OCC
Mob | 9(2)(a)

From: Helene.Carbonatto@health.govt.nz [mailto:Helene.Carbonatto@health.govt.nz]
Sent: Thursday, 4 June 2020 11:39 a.m.
To: David Meates <David.Meates@cdhb.health.nz>; Sue Nightingale <Sue.Nightingale@cdhb.health.nz>; 9(2)(a), AIRCDRE 9(2)(a)@NZDF.mil.nz>

Cc: Deborah.Woodley@health.govt.nz; Suz.Halligan@health.govt.nz
Subject: Letter CDHB Stand Up Christchurch Isolation Facilities

Hi all

Thanks again for today's useful discussion regarding the operating model for the managed isolation and quarantine facilities in Christchurch.

Please let me know if the attached reflects our discussion, and if there are any further changes you wish to make.

Nga mihi

Helene Carbonatto - Group Manager
COVID 19 Public Health Response
Ministry of Health I DHB Population Health and Prevention
Ministry of Health I Email: Helene.Carbonatto@health.govt.nz I Ph: 9(2)(a) [redacted]
[redacted]
http://www.health.govt.nz

From: Michelle.Arrowsmith@health.govt.nz
To: David Meates; John Hansen; lester.levy@9(2)(a)
Subject: Fwd: ASB Hagley Flood - Initial report[EXTERNAL SENDER]
Date: Tuesday, 2 June 2020 9:03:54 PM

Dear Sir John, David and Lester

This is an FYI. I'm assuming you are already aware as I know Mary and Tony have discussed today. We'll report further as information is available.

We have let 9(2)(a) know too.

Regards

Michelle Arrowsmith
Deputy Director General
DHB Performance Support and Infrastructure

Sent from my iPhone

Begin forwarded message:

> **From:** "Karl Wilkinson" <Karl.Wilkinson@health.govt.nz>
> **Date:** 2 June 2020 at 6:00:47 PM NZST
> **To:** "Anna McMartin" <Anna.McMartin@parliament.govt.nz>
> **Cc:** "Michelle Arrowsmith" <Michelle.Arrowsmith@health.govt.nz>
> **Subject: ASB Hagley Flood - Initial report**
>
> Good evening Anna,
>
> We have been made aware today of a flood in the new Christchurch Hospital Hagley building. The project team is currently reviewing cause and impact of the flooding, however initial information is;
> 1. The cause of flooding appears to be a valve failure on a heating system pipe at Level 5 in the east tower. It appears the valve failed over the weekend, and water from the heating system has discharged into the building.
> 2. An initial assessment of impact has identified flooding damage around the east tower area, from Level 5 to Level 2. This has affected ceilings and wall linings. Today has focused on clearing up the water, with more detailed assessment of damage now underway.
> 3. A review of the cause of the failure is also underway.
>
> It is possible that the repair work may delay completion of the project. The Ministry will have more details late this week on the extent of damage, repair works, and impact on building completion programme.
>
> Regards,
> Karl
>
> Karl Wilkinson
> Director, Health & Infrastructure
> DHB Performance, Support & Infrastructure
> Mobile: 9(2)(a)

****

Statement of confidentiality: This e-mail message and any accompanying

attachments may contain information that is IN-CONFIDENCE and subject to legal privilege.
If you are not the intended recipient, do not read, use, disseminate, distribute or copy this message or attachments.
If you have received this message in error, please notify the sender immediately and delete this message.
****

From: Michelle.Arrowsmith@health.govt.nz
To: David Meates; John Hansen
Cc: Lester Levy
Subject: Re: CDHB Master Plan Compliance Works Package
Date: Sunday, 28 June 2020 9:46:38 PM

Hi David

I'm just following up on below. I've asked my team to be explicit on what documentation is required for CIC for Tower 3 and compliance works. We need to progress this as soon as possible now in the next few weeks to reach CIC timely and ensure no other risks appear during this time.

I also really need a view on the suggested use of the funding for your DHB as part of the government $300m package to health. Both ministers have requested this report back from MoH asap. Could you provide your thoughts and suggestions by the end of this week.

Happy to discuss any of this David just call.

Thanks

Michelle Arrowsmith
Deputy Director General
DHB Performance Support and Infrastructure

Sent from my iPhone

On 16/06/2020, at 4:44 PM, Michelle Arrowsmith <Michelle.Arrowsmith@health.govt.nz> wrote:

> Kia Ora David
>
> Thanks for the opportunity for Karl to join the discussion on 28 May. Given you are all meeting tomorrow I thought it would be prudent to provide you the MoH view and our expectations of the meeting tomorrow. Apologies for the delay in getting this to you.
>
> We appreciate you sharing your notes of the meeting of 28 May David. Taking onboard the focus of the discussion, Karl took a slightly different view of the meeting from your notes and I summarise his main points and next steps for progression below as;
>
> - compliance issues are required in addition to Tower 3
> - CDHB has $21m of remaining Earthquake Funds to contribute to compliance of health and safety issues
> - the minimal compliance issues to be considered include structural panel repairs, passive fire compliance, and seismic upgrade (where needed for post earthquake functionality)
> - it is noted many of the areas in the older buildings rate poorly for clinical fitness-for-purpose (6 bedded ward rooms, bed to shower/toilet ratio, etc)
> - there is a need to be realistic about the post-Covid environment and the likely availability of capital for the Christchurch campus and the timeframes (likely to be lengthened)
> - in that context the DHB Board, management, MOH, consultants and compliance agencies (CCC) will need to be open to a full consideration of any other solutions that may address capacity issues in a post Covid environment, including clinical and operating models and possible different capacity utilisation across the CDHB facilities
> - the CDHB Board, management, MOH and consultants are to develop a range of alternative scenarios based on existing facilities continuing to be used over the next 5/10/15 year timelines. These scenario's are to highlight impacts /requirements on compliance and health and safety.

For tomorrow's workshop we have asked Sir John your Board Chair to chair the meeting for us all and the Ministry will support the facilitation of this workshop. We appreciate your agenda and thanks for circulating to everyone.

To be able to achieve our collective desired outcome of a defined minimal compliance package to compliment Tower 3 we will need to step back to the core issues and look beyond the solutions that have to date been developed through the masterplan (understanding the current capital context). It will be important to expedite this work to ensure a plan for both compliance and Tower 3 can be provided to CIC as soon as possible. The longer this takes the higher the risk in a constrained capital and fiscal environment. I urge you and the rest of the wider team to drive this work forward in a timely way.

In addition to this there is the matter of your place holder of $5m as part of the wider Health $300m package announced by Government. I understand that you had suggested to the HIU team that this be used for fit out of maternity and endoscopy units, however I understand these are leased properties and this isn't MoH normal process to approve this in a building not Crown owned. We would appreciate a discussion and view of alternates that would fit with this place holder funding for CDHB. Again we really need to expedite this process as part of responding to the Governments funding package. I am hoping you may have chance to discuss tomorrow and if not could I ask that you progress a conversation with the investment management team before the end of the week on this matter. I suggest you contact Jo Strachan-Hope in the first instance.

No doubt you and the DHB team have continued further thinking or work on the compliance plan since the meeting in May and I look forward to hear about the discussion and an agreed solution following tomorrows meeting.

Nga mihi
Michelle

Michelle Arrowsmith
Deputy Director-General
DHB Performance Support & Infrastructure
Ministry of Health
Mobile: 9(2)(a) [redacted]

****

****

From: Helene.Carbonatto@health.govt.nz
To: David Meates
Cc: Webb Aircdre; Deborah.Woodley@health.govt.nz; Sue Nightingale; Susan Fitzmaurice; Suz.Halligan@health.govt.nz
Subject: RE: Facilities operating model [EXTERNAL SENDER]
Date: Wednesday, 3 June 2020 6:00:10 PM
Attachments: ATT00001.gif
ATT00002.jpg
ATT00003.jpg
ATT00004.gif

Hi
No sorry - Deborah has an ELT meeting at that time which she is unable to get out of.
Alternatively, if David and Sue are happy to meet with 9(2)(a) and myself, am happy to have the discussion at that time and we can work through what needs doing and update Deborah after that.
Nga mihi

Helene Carbonatto - Group Manager
COVID 19 Public Health Response
Ministry of Health I DHB Population Health and Prevention
Ministry of Health I Email: Helene.Carbonatto@health.govt.nz I Ph: 9(2)(a)
[redacted]
http://www.health.govt.nz

From: "David Meates" <David.Meates@cdhb.health.nz>
To: "'Helene.Carbonatto@health.govt.nz'" <Helene.Carbonatto@health.govt.nz>, "Webb Aircdre" 9(2)(a) [redacted] "David Meates" <David.Meates@cdhb.health.nz>, "Sue Nightingale" <Sue.Nightingale@cdhb.health.nz>, "Deborah.Woodley@health.govt.nz" <Deborah.Woodley@health.govt.nz>
Cc: "Suz.Halligan@health.govt.nz" <Suz.Halligan@health.govt.nz>
Date: 03/06/2020 05:48 pm
Subject: RE: Facilities operating model [EXTERNAL SENDER]
Sent by: "Susan Fitzmaurice" <Susan.Fitzmaurice@cdhb.health.nz>

Hi Helene

Just responding on behalf of David and Sue. Is it possible to have this urgent discussion at 8.30am tomorrow morning which they are both available for?

Thanks
Susan

Susan Fitzmaurice | EA to David Meates, Chief Executive
Canterbury District Health Board and West Coast District Health Board

03 364 4110 | susan.fitzmaurice@cdhb.health.nz
P O Box 1600, Christchurch
www.cdhb.health.nz | www.westcoastdhb.org.nz

[redacted] [redacted]

Values – A Matou Uara
Care and respect for others - Manaaki me te whakaute i te tangata | Integrity in all we do - Hapai i a matou mahi katoa i runga i te pono | Responsibility for outcomes - Te Takohanga i nga hua

From: Helene.Carbonatto@health.govt.nz [mailto:Helene.Carbonatto@health.govt.nz]
Sent: Wednesday, 3 June 2020 5:24 p.m.
To: Webb Aircdre 9(2)(a) [redacted]; David Meates <David.Meates@cdhb.health.nz>; Sue Nightingale <Sue.Nightingale@cdhb.health.nz>; Deborah.Woodley@health.govt.nz
Cc: Suz.Halligan@health.govt.nz
Subject: Facilities operating model [EXTERNAL SENDER]

Hi all
I'd like to convene an urgent discussion tomorrow re the operating model for managed facilities in Christchurch as discussed. David/Sue are you free at all tomorrow either at 9.30-10 or alternatively anytime between 12-1.30 for 30 minutes?
Nga mihi

Helene Carbonatto - Group Manager
COVID 19 Public Health Response
Ministry of Health I DHB Population Health and Prevention
Ministry of Health I Email: Helene.Carbonatto@health.govt.nz I Ph: 9(2)(a) [redacted]
[redacted]
http://www.health.govt.nz
****

If you have received this message in error, please notify the sender immediately and delete this message.
****

****

Statement of confidentiality: This e-mail message and any accompanying attachments may contain information that is IN-CONFIDENCE and subject to legal privilege.
If you are not the intended recipient, do not read, use, disseminate, distribute or copy this message or attachments.
If you have received this message in error, please notify the sender immediately and delete this message.
****

This e-mail message has been scanned for Viruses and Content and cleared by the Ministry of Health's Content and Virus Filtering Gateway

From: Helene.Carbonatto@health.govt.nz
To: David Meates
Cc: Webb Aircdre; Deborah.Woodley@health.govt.nz; Sue Nightingale; Susan Fitzmaurice; Suz.Halligan@health.govt.nz
Subject: RE: Facilities operating model [EXTERNAL SENDER]
Date: Wednesday, 3 June 2020 6:30:58 PM
Attachments: ATT00001.gif
ATT00002.gif
ATT00003.jpg
ATT00004.jpg
ATT00005.gif

Thanks yes please. 9(2)(a) hope this time suits?
Nga mihi

Helene Carbonatto - Group Manager
COVID 19 Public Health Response
Ministry of Health I DHB Population Health and Prevention
Ministry of Health I Email: Helene.Carbonatto@health.govt.nz I Ph: 9(2)(a)
[redacted]
http://www.health.govt.nz

From: "David Meates" <David.Meates@cdhb.health.nz>
To: "'Helene.Carbonatto@health.govt.nz'" <Helene.Carbonatto@health.govt.nz>, "David Meates" <David.Meates@cdhb.health.nz>
Cc: "Webb Aircdre" 9(2)(a) [redacted], "Deborah.Woodley@health.govt.nz" <Deborah.Woodley@health.govt.nz>, "Sue Nightingale" <Sue.Nightingale@cdhb.health.nz>, "Suz.Halligan@health.govt.nz" <Suz.Halligan@health.govt.nz>
Date: 03/06/2020 06:12 pm
Subject: RE: Facilities operating model [EXTERNAL SENDER]
Sent by: "Susan Fitzmaurice" <Susan.Fitzmaurice@cdhb.health.nz>

That would be great. Do you want me to send a Zoom appointment for tomorrow morning?
Susan

From: Helene.Carbonatto@health.govt.nz [mailto:Helene.Carbonatto@health.govt.nz]
Sent: Wednesday, 3 June 2020 6:00 p.m.
To: David Meates <David.Meates@cdhb.health.nz>
Cc: Webb Aircdre 9(2)(a) [redacted] Deborah.Woodley@health.govt.nz; Sue Nightingale <Sue.Nightingale@cdhb.health.nz>; Susan Fitzmaurice <Susan.Fitzmaurice@cdhb.health.nz>; Suz.Halligan@health.govt.nz
Subject: RE: Facilities operating model [EXTERNAL SENDER]

Hi
No sorry - Deborah has an ELT meeting at that time which she is unable to get out of.
Alternatively, if David and Sue are happy to meet with 9(2)(a) and myself, am happy to have the discussion at that time and we can work through what needs doing and update Deborah after that.
Nga mihi

Helene Carbonatto - Group Manager
COVID 19 Public Health Response
Ministry of Health I DHB Population Health and Prevention

Ministry of Health I Email: Helene.Carbonatto@health.govt.nz I Ph: 9(2)(a)
[redacted]
http://www.health.govt.nz

From: "David Meates" <David.Meates@cdhb.health.nz>
To: "'Helene.Carbonatto@health.govt.nz'" <Helene.Carbonatto@health.govt.nz>, "Webb Aircdre" 9(2)(a) [redacted], "David Meates" <David.Meates@cdhb.health.nz>, "Sue Nightingale" <Sue.Nightingale@cdhb.health.nz>, "Deborah.Woodley@health.govt.nz" <Deborah.Woodley@health.govt.nz>
Cc: "Suz.Halligan@health.govt.nz" <Suz.Halligan@health.govt.nz>
Date: 03/06/2020 05:48 pm
Subject: RE: Facilities operating model [EXTERNAL SENDER]
Sent by: "Susan Fitzmaurice" <Susan.Fitzmaurice@cdhb.health.nz>

Hi Helene

Just responding on behalf of David and Sue. Is it possible to have this urgent discussion at 8.30am tomorrow morning which they are both available for?

Thanks
Susan

Susan Fitzmaurice | EA to David Meates, Chief Executive
Canterbury District Health Board and West Coast District Health Board

03 364 4110 | susan.fitzmaurice@cdhb.health.nz
P O Box 1600, Christchurch
www.cdhb.health.nz | www.westcoastdhb.org.nz

Values – A Matou Uara
Care and respect for others - Manaaki me te whakaute i te tangata | Integrity in all we do - Hapai i a matou mahi katoa i runga i te pono | Responsibility for outcomes - Te Takohanga i nga hua

From: Helene.Carbonatto@health.govt.nz [mailto:Helene.Carbonatto@health.govt.nz]
Sent: Wednesday, 3 June 2020 5:24 p.m.
To: Webb Aircdre 9(2)(a) ; David Meates <David.Meates@cdhb.health.nz>; Sue Nightingale <Sue.Nightingale@cdhb.health.nz>; Deborah.Woodley@health.govt.nz
Cc: Suz.Halligan@health.govt.nz
Subject: Facilities operating model [EXTERNAL SENDER]

Hi all
I'd like to convene an urgent discussion tomorrow re the operating model for managed facilities in Christchurch as discussed. David/Sue are you free at all tomorrow either at 9.30-10 or alternatively anytime between 12-1.30 for 30 minutes?
Nga mihi

Helene Carbonatto - Group Manager
COVID 19 Public Health Response
Ministry of Health I DHB Population Health and Prevention
Ministry of Health I Email: Helene.Carbonatto@health.govt.nz I Ph: 9(2)(a)
http://www.health.govt.nz
****

****

Statement of confidentiality: This e-mail message and any accompanying attachments may contain information that is IN-CONFIDENCE and subject to legal privilege.
If you are not the intended recipient, do not read, use, disseminate, distribute or copy this message or attachments.
If you have received this message in error, please notify the sender immediately and delete this message.
****

This e-mail message has been scanned for Viruses and Content and cleared by the Ministry of Health's Content and Virus Filtering Gateway

From: Tony.Lloyd@health.govt.nz
To: John Hansen; 9(2)(a) ; David Meates
Cc: Mary Gordon (Executive Director of Nursing); Karl.Wilkinson@health.govt.nz
Subject: Status Update - Flood Level 5[EXTERNAL SENDER]
Date: Friday, 5 June 2020 2:04:04 PM
Attachments: IMG_3115.jpg
IMG_3116.jpg
IMG_3118.jpg
IMG_3119.jpg
IMG_3120.jpg

Dear HRPG Members,

The flood in the new Christchurch Hospital Hagley building that occurred earlier this week has resulted in water damage to a number of areas in the visitor space of wards located in the Eastern Tower. The initial reports indicate that a valve malfunctioned/failed resulting in a reasonably substantial amount of water tracking down through the levels immediately below Level 5. CPB have been drying and dehumidifying the areas since the flood was detected.

I have instructed the design team in conjunction with CPB to immediately survey the damaged areas to determine the extent and advise on the appropriate remedy. I have also requested they commence removal of wall board, ceiling panels and carpet tiles where there is damage on Level 5. Other areas are to be assessed.

An insurance assessor is on site surveying the areas in anticipation of a claim under the contract works policy.

I do not know what the full impact on programme will be until the full extent is known but would like to repair the areas concurrently with the balance of the finishing works occurring in the remainder of the building so as not to loose time. I will need to advise you of the full impact on programme in the coming days.

I am also mindful that there are other building systems that may have been affected such as fire proofing on steel, ducting, cabling etc. These will also be checked for damage.

The valve that failed is one of approximately 900 in the building. The manufacturer of the drain valve, Beca and CPB are investigating the cause for the failure and will advise of any further action required to provide confidence to the integrity of the product.

I visited site yesterday and enclose some photos for your reference.

I will keep you appraised as more information comes to hand.

Regards

Tony

Tony Lloyd
Programme Director
DHB Performance, Support & Infrastructure
Ministry of Health

133 Molesworth Street
PO Box 5013
WELLINGTON 6011
mailto:from 29/5/19 tony.lloyd@health.govt.nz
****

Kathleen Smitheram

From: Paula.Steven@health.govt.nz on behalf of Michelle.Arrowsmith@health.govt.nz
Sent: Tuesday, 2 June 2020 9:06 PM
To: David Meates
Cc: Susan Fitzmaurice
Subject: MOH / CDHB Performance Meeting
Attachments: ministry_of_health_Performance meeting-template - June 2020 - final.pptx

Kia ora David

Please find attached template for completion that will act as the agenda for our meeting on Friday.

Any questions please let me know.

Ngā mihi
Michelle

Michelle Arrowsmith
Deputy Director-General
DHB Performance Support & Infrastructure
Ministry of Health
Mobile: 9(2)(a)

MINISTRY OF HEALTH
MANATŪ HAUORA

DHB Performance meeting

XXX DHB

Date: XX June 2020

Overall Annual Plan Performance 2019/20

Achievements	Improvement Focus
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.

Financial Performance Refer Table 1

Discussion points

1. YTD results
2. Year-end plan
   - forecast including achieving agreed savings, potential for additional savings, management of known risks, discussion of any new risks and management strategies
3. FTE
   - Actual against plan and outsourced personnel
4. Run Rates
5. Cash Forecast

Response/Action points

1.
2.
3.
4.
5.

Areas of Focus

Discussion points	Response/Action points
1. Balanced Scorecard/Analytics 2. Winter Preparedness 3. Public Health Performance • Tracking • Testing • Support 4. Influenza vaccinations	1. 2. 3. 4.

Clinical Performance

Discussion points

1. Planned Care including equity
   - ESPI 2 & 5
   - Delivery to plan (Covid19/Capacity planning)
   - Equity response
2. Unplanned Care
   - ED 6hr wait
   - Primary Care
3. Radiology (Hospital & Community)
4. Clinical Safety and Quality

Response /Action points

1.
2.
3.
4.

Capital

Discussion points

1. Update on agreed capital expenditure
   - Health Capital Envelope (HCE)
   - Health Investment Package (national $300 million package)
   - Other Capital
2. Proposed Capital expenditure
3. Future long term capital plans
   - Asset Management Planning, alignment to national programme

Response /Action points

1.
2.
3.

Proposed Actions from Meeting

No.	Item	Actions	Completed by or SRO	Date
1.				
2.				
3.				
4.				
5.				

Kathleen Smitheram

From: Helene.Carbonatto@health.govt.nz
Sent: Thursday, 4 June 2020 11:39 AM
To: David Meates; Sue Nightingale; Webb Aircdre
Cc: Deborah.Woodley@health.govt.nz; Suz.Halligan@health.govt.nz
Subject: Letter CDHB Stand Up Christchurch Isolation Facilities
Attachments: Letter CDHB Stand Up Christchurch Isolation Facilities.docx

Hi all

Thanks again for today's useful discussion regarding the operating model for the managed isolation and quarantine facilities in Christchurch.

Please let me know if the attached reflects our discussion, and if there are any further changes you wish to make.

Ngā mihi

Helene Carbonatto - Group Manager
COVID 19 Public Health Response
Ministry of Health I DHB Population Health and Prevention
Ministry of Health I Email: Helene.Carbonatto@health.govt.nz I Ph: 9(2)(a) [redacted]

MINISTRY OF HEALTH
MANATŪ HAUORA

http://www.health.govt.nz

133 Molesworth Street
PO Box 5013
Wellington 6140
New Zealand
T+64 4 496 2000

4 June 2020

David Meates
Chief Executive
Canterbury District Health Board
Christchurch

Dear David

Stand up of Christchurch Isolation and Quarantine Facilities

Please firstly accept the Ministry of Health's gratitude for work to date to support the COVID-19 response. In particular, the efforts your team have taken to support the return of New Zealanders across the border and within the isolation and quarantine service that they have delivered to date.

As you are aware New Zealand continues to receive an increasing number of passengers across the border and we are seeing our Auckland facilities beginning to reach capacity. In line with this, we need to re-instate the facilities within Christchurch to support this demand. It is predicted that Auckland will meet capacity on the 9th June so there would be a need to stand up facilities prior to that.

The minimum service provisions that would be required are:

- Provide a health assessment (COVID-19 symptom check) service for all managed isolation and quarantine facilities
- Undertake a COVID-19 swab for all residents on day 3 and 12 of their isolation
- Provide immediate need primary health care as required
- Provide access to allied health care services for any immediate needs
- Ensure a mental health care pathway and immediate support system is provided
- Enforce protocols to ensure that cases of COVID-19 are identified, contained and referred.
- Ensure strong clinical governance (including quality and risk management practices) and health and safety protocols are in place.
- Maintain engagement with key stakeholders - health care providers, RIQ, DHB, PHU, and MoH.
- Ensure welfare and wellness needs are catered for.
- Integrate into Public Health service for case investigation and contact tracing
- Integrate information into the National Contact Tracing System (as it is stood up for isolation and quarantine)
- Maintain MoH reporting requirements through the Regional Isolation and Quarantine (RIQ)

- Follow MoH policy and guidance, ensuring any required changes are discussed with the MoH.

As discussed today, the operating model for this service will see Canterbury DHB take the health leadership function across facilities, which includes provision and commissioning of services into the facilities as well as the clinical governance for these services. The Regional Isolation and Quarantine (RIQ) coordination cell will be stood up to lead the facilities and logistics component of the operation and they will be accountable to the Isolation, Quarantine and Repatriation team in the National Crisis Management Centre. Both health and RIQ will need to work closely together to be clear of each other's roles and accountabilities and resolve key issues as they arise.

The Ministry of Health's role is the funder of these services, and our role is to provide the health policy and standards for what is expected to be delivered from health into these facilities. These will then form the basis for the regulatory framework we are currently developing for these facilities. We agreed today that Canterbury DHB, alongside the Auckland DHBs who are looking to stand up the health management component from July, will work with the Ministry on the core minimum standards for these facilities. I am open to reviewing and understanding what best practice on the ground should look like, and the operating manual you have developed will be a good starting point for this discussion.

As discussed, the Ministry will fund the core components related to the management and key onsite services for the operation. We also expect the DHB to extend and in reach a number of its core clinical services into the facilities (such as mental health addiction services). I will come back to you shortly on the proposed funding for discussion.

Yours sincerely

Deborah Woodley
Deputy Director General
Population Health and Prevention

From: Lisa.Rodgers@health.govt.nz on behalf of Helene.Carbonatto@health.govt.nz
To: David Meates
Cc: Sue Nightingale; Michelle.Arrowsmith@health.govt.nz
Subject: Stand up of Christchurch Isolation and Quarantine Facilities
Date: Thursday, 11 June 2020 4:23:01 PM
Attachments: ATT00001.gif
20200611_D Meates CDHB.pdf

Hi David

Please find attached the letter regarding health services into isolation and quarantine facilities.

Nga mihi

Helene Carbonatto - Group Manager
COVID 19 Public Health Response
Ministry of Health I DHB Population Health and Prevention
Ministry of Health I Email: Helene.Carbonatto@health.govt.nz I Ph: 9(2)(a) [redacted]

http://www.health.govt.nz

133 Molesworth Street
PO Box 5013
Wellington 6140
New Zealand
T+64 4 496 2000

11 June 2020

David Meates
Chief Executive
Canterbury District Health Board
Christchurch

Dear David

Stand up of Christchurch Isolation and Quarantine Facilities

Please firstly accept the Ministry of Health's gratitude for work to date to support the COVID-19 response. In particular, the efforts your team have taken to support the return of New Zealanders across the border and within the isolation and quarantine service that they have delivered to date.

As you are aware New Zealand continues to receive an increasing number of passengers across the border and we are seeing our Auckland facilities beginning to reach capacity. In line with this, we need to re-instate the facilities within Christchurch to support this demand. It is predicted that Auckland will meet capacity on the 9th June so there would be a need to stand up facilities prior to that.

The minimum service provisions that would be required are:

- Provide a health assessment (COVID-19 symptom check) service for all guests at managed isolation and quarantine facilities
- Undertake a COVID-19 swab for all residents on day 3 and 12 of their isolation
- Provide immediate need primary health care as required
- Provide access to allied health care services for any immediate needs
- Ensure a mental health care pathway and immediate support system is provided
- Enforce protocols to ensure that cases of COVID-19 are identified, contained and referred to appropriate health facilities..
- Ensure strong clinical governance (including quality and risk management practices) and health and safety protocols are in place.
- Provide all partner agencies with advice to ensure health and safety plans and protocols for staff management and safety reflect best practice.
- Maintain engagement with key stakeholders - health care providers, RIQ, DHB, PHU, and MoH.
- Ensure welfare and wellness needs are catered for.
- Integrate into Public Health service for case investigation and contact tracing
- Integrate information into the National Contact Tracing System (as it is stood up for isolation and quarantine)

- Maintain MoH reporting requirements through the Regional Isolation and Quarantine (RIQ)
- Follow MoH policy and guidance, ensuring any required changes are discussed with the MoH.

As discussed, the operating model for this service will see Canterbury DHB take the health leadership function across facilities, which includes provision and commissioning of services into the facilities as well as the clinical governance for these services. This includes modification of health protocols where appropriate based on expert Infection Prevention and Control Advice and with agreement from Ministry of Health. The Regional Isolation and Quarantine (RIQ) coordination cell will be stood up to lead the facilities and logistics component of the operation and they will be accountable to the Isolation, Quarantine and Repatriation team in the National Crisis Management Centre. Both health and RIQ will need to work closely together to be clear of each other's roles and accountabilities and resolve key issues as they arise.

The Ministry of Health's role is the funder of these services, and our role is to provide the health policy and standards for what is expected to be delivered from health into these facilities. These will then form the basis for the regulatory framework we are currently developing for these facilities. We agreed today that Canterbury DHB, alongside the Auckland DHBs who are looking to stand up the health management component from July, will work with the Ministry on the core minimum standards for these facilities. I am open to reviewing and understanding what best practice on the ground should look like, and the operating manual you have developed will be a good starting point for this discussion.

The Ministry of Health will provide a single point of contact for communication and advice to the CDHB and will respond to communications in a timely way. Weekly meetings between the RIQ, DHBs and Ministry will be in place.

As discussed, the Ministry will fund the core components related to the management and key onsite services for the operation. We also expect the DHB to extend and in reach a number of its core clinical services into the facilities (such as mental health addiction services). If you can come to us on potential costs for the delivery of services into the facilities, we can discuss the funding approach.

Yours sincerely

Deborah Woodley
Deputy Director-General
Population Health and Prevention

Kathleen Smitheram

From: Paula.Steven@health.govt.nz on behalf of Michelle.Arrowsmith@health.govt.nz
Sent: Monday, 27 July 2020 4:01 PM
To: David Meates; John Hansen
Subject: CEO update re dates confirmed for Christchurch Hospital Hagley move

Importance: High

Kia ora David / Sir John

The Minister has advised that no information has to be released today with regards to the confirmed dates for Christchurch Hospital Hagley move in the CEO update.

The Minister's office will release this information tomorrow.

If you would like to discuss please feel free to give me a call.

Ngā mihi
Michelle

Michelle Arrowsmith
Deputy Director-General
DHB Performance Support & Infrastructure
Ministry of Health
Mobile: 9(2)(a)

From: Ashley.Bloomfield@health.govt.nz
To: David Meates
Subject: Fw: Vital information[EXTERNAL SENDER]
Date: Sunday, 19 July 2020 2:56:34 PM
Attachments: ATT00001.jpg
ATT00002.jpg

Hi David
I thought you should see this interesting set of emails from one of your West Coast staff members.
Kind regards
Ashley

Dr Ashley Bloomfield
Director-General of Health

email: ashley.bloomfield@health.govt.nz
Mobile: 9(2)(a)
www.health.govt.nz

----- Forwarded by Ashley Bloomfield/MOH on 19/07/2020 02:55 pm -----

From: '9(2)(a)@wcdhb.health.nz>
To: "'d.clark@ministers.govt.nz'" <d.clark@ministers.govt.nz>, "'david.clark@parliment.govt.nz'" <david.clark@parliment.govt.nz>, "'Jacinda.Ardern@parliament.govt.nz'" <Jacinda.Ardern@parliament.govt.nz>, "'Ashley.Bloomfield@health.govt.nz'" <Ashley.Bloomfield@health.govt.nz>
Cc: "'Toni Sims'" <Toni.Sims@parliament.govt.nz>, "'w.peters@ministers.govt.nz'" <w.peters@ministers.govt.nz>, "'damien.oconnor@parliament.govt.nz'" <damien.oconnor@parliament.govt.nz>
Date: 01/07/2020 02:59 pm
Subject: FW: Vital information

Please see below I have tried to make contact through parliament if the ministers do not want to understand the impact of COVID 19 protocols on front line staff from one of the very few people in NZ with experience and valuable insight then what is the point of having ministers with portfolios in health. There would be no health system without front line staff.
I feel I have been fobbed of by numerous members of parliament when all it would take is a quick phone call or email to ask me what needs to occur to ensure the staff who are dealing with these situations whilst everyone else is tucked up at home safe in lockdown feel safe and supported.

I am disappointed that my experience with this is not valued by our government yet we are happy to go on TV and thank and commend Jenny from Invercargill for looking after Boris Johnson when he had COVID 19. Where is the path for our own countries staff to provide information to the people that lead our country and make policy for health care provision when people continue to get fobbed off.

I am also disappointed that the minster of health's office has not acknowledged any correspondence that has been forwarded in relation to this.

Kind Regards

9(2)(a)

9(2)(a) [redacted]

From: PM Invites [mailto:PM.Invites@parliament.govt.nz]
Sent: Wednesday, 1 July 2020 11:49 a.m.
To: 9(2)(a) [redacted]@wcdhb.health.nz>
Subject: RE: Vital information

Kia ora 9(2)(a) [redacted]

Many thanks for your email and request to meet with the Prime Minister. Unfortunately the Prime Minister will be unable to meet with you due to schedule constraints. If you still have not had a response form the Minister of Health's office, I would advise you to follow-up via d.clark@ministers.govt.nz

Nga mihi,

9(2)(a) [redacted] | **Private Secretary**
Office of the Prime Minister

Authorised by Rt. Hon Jacinda Ardern MP, Parliament Buildings, Wellington

From: 9(2)(a) [redacted]@wcdhb.health.nz]
Sent: Friday, 12 June 2020 5:51 PM
To: Rt. Hon Jacinda Ardern <Jacinda.Ardern@parliament.govt.nz>
Subject: RE: Vital information

Hello again,
I understand the Prime Minister Ardern is coming to Greymouth to open our new hospital with the Minister of Health? I understand her time is precious and she will have a tight schedule but I would like 10 min with her to discuss what I previously emailed as I have heard nothing from the Minister of Healths office and my experience is so critical to planning for future pandemics/health emergencies.
Do you rgink this could be organized.

9(2)(a) [redacted]

On 2/05/2020 10:40 am, "Rt. Hon Jacinda Ardern" <Jacinda.Ardern@parliament.govt.nz> wrote:
Dear 9(2)(a) [redacted]
Thank you so much for writing to the Prime Minister, Jacinda Ardern, to let her know about your experiences nursing the COVID-19 patient who sadly passed away on the West Coast. I'm so sorry for the delay in replying to you – as you can imagine we've been getting unprecedented numbers of emails, so it has taken longer than usual to get back to you.

I hope you don't mind, but I've also passed your email on to the Minister of Health's office, as the issues you've raised are things which fall into his area of responsibility, and are something they will be able to address in more detail, but I will also pass your
comments onto the Prime Minister so that she is aware of them.
Thank you so much for your work – it must have been a very, very difficult time for you, and for everyone involved.
Kindest regards
9(2)(a)

9(2)(a)
Office of the Prime Minister

Authorised by Rt Hon Jacinda Ardern MP, Parliament Buildings Wellington 6012

From: 9(2)(a) @wcdhb.health.nz]
Sent: Monday, 20 April 2020 4:51 PM
To: Rt. Hon Jacinda Ardern <Jacinda.Ardern@parliament.govt.nz>
Subject: Vital information

Hello Prime Minister Ardern,

I was wondering if I could discuss with you the impact of COVID19 for nursing staff. I was a lone New Zealander for some time as I nursed our first Covid death until she died. The vital information I have is in regards to the support needed post event. As no one in NZ had done that before including managing the deceased body and managing family (you are probably aware family were with her when she passed) I had to work it out myself based on my vast nursing and compassionate knowledge. We have policies and procedures in place now but I am referring to looking after our psychological well being afterwards as it is a different situation than nursing either an expected death or an acute situation. If this is something of interest to you please contact me.

9(2)(a)

This message has been scanned and found to be free of known security risks.
The Information contained in this message and or attachments is intended only for the person or entity to which it is addressed and may contain confidential and or privileged material. Any review, retransmission, dissemination or other use of, or taking of any action in reliance upon, this information by person or entities other than the intended recipient is prohibited. If you receive this in error, please contact the sender and delete the material from your system and destroy any copies.

From: Paula.Steven@health.govt.nz on behalf of Michelle.Arrowsmith@health.govt.nz
To: David Meates
Cc: John Hansen
Subject: Re: CEO update re dates confirmed for Christchurch Hospital Hagley move[EXTERNAL SENDER]
Date: Monday, 27 July 2020 4:21:15 PM

Thanks for the conformation.

Nga mihi
Michelle

Michelle Arrowsmith
Deputy Director-General
DHB Performance Support & Infrastructure
Ministry of Health
Mobile: 9(2)(a)

From: "David Meates" <David.Meates@cdhb.health.nz>
To: "Michelle.Arrowsmith@health.govt.nz" <Michelle.Arrowsmith@health.govt.nz>
Cc: "John Hansen" <John.Hansen@cdhb.health.nz>
Date: 27/07/2020 04:14 pm
Subject: Re: CEO update re dates confirmed for Christchurch Hospital Hagley move

---

Kia ora Michelle

Not being included in CEO update.

David Meates MNZM
CEO Canterbury and West Coast DHBs

On 27/07/2020, at 4:01 PM, "Michelle.Arrowsmith@health.govt.nz" <Michelle.Arrowsmith@health.govt.nz> wrote:

Kia ora David / Sir John

The Minister has advised that no information has to be released today with regards to the confirmed dates for Christchurch Hospital Hagley move in the CEO update.

The Minister's office will release this information tomorrow.

If you would like to discuss please feel free to give me a call.

Nga mihi
Michelle

Michelle Arrowsmith
Deputy Director-General
DHB Performance Support & Infrastructure
Ministry of Health
Mobile: 9(2)(a)

****

attachments may contain information that is IN-CONFIDENCE and subject to legal privilege.
If you are not the intended recipient, do not read, use, disseminate, distribute or copy this message or attachments.
If you have received this message in error, please notify the sender immediately and delete this message.
****

****

Statement of confidentiality: This e-mail message and any accompanying attachments may contain information that is IN-CONFIDENCE and subject to legal privilege.
If you are not the intended recipient, do not read, use, disseminate, distribute or copy this message or attachments.
If you have received this message in error, please notify the sender immediately and delete this message.
****

This e-mail message has been scanned for Viruses and Content and cleared by the Ministry of Health's Content and Virus Filtering Gateway

From: Michelle.Arrowsmith@health.govt.nz
To: David Meates
Cc: John Hansen
Subject: Re: CEO update re dates confirmed for Christchurch Hospital Hagley move[EXTERNAL SENDER]
Date: Monday, 27 July 2020 9:53:22 PM

Thanks David

Michelle Arrowsmith
Deputy Director General
DHB Performance Support and Infrastructure

Sent from my iPhone

On 27/07/2020, at 4:14 PM, David Meates <David.Meates@cdhb.health.nz> wrote:

> Kia ora Michelle
>
> Not being included in CEO update.
>
> David Meates MNZM
> CEO Canterbury and West Coast DHBs
>
> > On 27/07/2020, at 4:01 PM, "Michelle.Arrowsmith@health.govt.nz" <Michelle.Arrowsmith@health.govt.nz> wrote:
> >
> > Kia ora David / Sir John
> >
> > The Minister has advised that no information has to be released today with regards to the confirmed dates for Christchurch Hospital Hagley move in the CEO update.
> >
> > The Minister's office will release this information tomorrow.
> >
> > If you would like to discuss please feel free to give me a call.
> >
> > Nga mihi
> > Michelle
> >
> > Michelle Arrowsmith
> > Deputy Director-General
> > DHB Performance Support & Infrastructure
> > Ministry of Health
> > Mobile: 9(2)(a)
> > **********
> > Statement of confidentiality: This e-mail message and any accompanying attachments may contain information that is IN-CONFIDENCE and subject to legal privilege.
> > If you are not the intended recipient, do not read, use, disseminate, distribute or copy this message or attachments.
> > If you have received this message in error, please notify the sender immediately and delete this message.
> > **********
> > ---
> > This e-mail message has been scanned for Viruses and Content and cleared by the Ministry of Health's Content and Virus Filtering Gateway
> > ---

****
Statement of confidentiality: This e-mail message and any accompanying attachments may contain information that is IN-CONFIDENCE and subject to legal privilege.

From: David Meates
To: Michelle.Arrowsmith@health.govt.nz
Cc: John Hansen
Subject: Re: CEO update re dates confirmed for Christchurch Hospital Hagley move
Date: Monday, 27 July 2020 4:14:03 PM

Kia ora Michelle

Not being included in CEO update.

David Meates MNZM
CEO Canterbury and West Coast DHBs

> On 27/07/2020, at 4:01 PM, "Michelle.Arrowsmith@health.govt.nz" <Michelle.Arrowsmith@health.govt.nz> wrote:
>
> Kia ora David / Sir John
>
> The Minister has advised that no information has to be released today with regards to the confirmed dates for Christchurch Hospital Hagley move in the CEO update.
>
> The Minister's office will release this information tomorrow.
>
> If you would like to discuss please feel free to give me a call.
>
> Nga mihi
> Michelle
>
> Michelle Arrowsmith
> Deputy Director-General
> DHB Performance Support & Infrastructure
> Ministry of Health
> Mobile: 9(2)(a)
> **********
>
> Statement of confidentiality: This e-mail message and any accompanying attachments may contain information that is IN-CONFIDENCE and subject to legal privilege.
> If you are not the intended recipient, do not read, use, disseminate, distribute or copy this message or attachments.
> If you have received this message in error, please notify the sender immediately and delete this message.
> **********
>
> This e-mail message has been scanned for Viruses and Content and cleared by the Ministry of Health's Content and Virus Filtering Gateway

From: Michelle.Arrowsmith@health.govt.nz
To: Kirsty.Doig@health.govt.nz
Cc: David Meates; Karalyn van Deursen; Karl.Wilkinson@health.govt.nz; John Hansen
Subject: Re: draft Hagley PR for the Minister"s office - urgent
Date: Monday, 27 July 2020 1:48:58 PM

Hi Kirsty

This looks fine to me but as you say please just check that we have all facts correct.

I think it's important as a MoH delivered build that the Minister is given opportunity to announce the dates and progress ahead of the media picking this up from DHB staff. It might be good if Ministers office agree to have a Board Chair comment alongside the Minister, not sure if this is possible Kirsty could you check.

Thanks Kirsty

Nga mihi
Michelle

Michelle Arrowsmith
Deputy Director-General
DHB Performance Support & Infrastructure
Ministry of Health
Mobile: 9(2)(a)

From: Kirsty Doig/MOH
To: Michelle Arrowsmith/MOH@MOH, "David Meates" <David.Meates@cdhb.health.nz>, karalyn.vandeursen@cdhb.health.nz, Karl Wilkinson/MOH@MOH,
Date: 27/07/2020 01:01 p.m.
Subject: draft Hagley PR for the Minister's office - urgent

Hi there Michelle / David

Following Karalyn's email this morning on some internal comms going out on Hagley timings, I've checked with the Minister's office & they're still keen to announce this, & ahead of all staff being informed & it going out in the CEO weekly update. I've done a quick draft PR below, largely based of info we've previously used. I'm just checking whether we can use the updated $ figure. Can you let me know if you have any feedback on the below.

Thanks, Kirsty

Dates confirmed for Christchurch Hospital Hagley move

Health Minister Chris Hipkins welcomes confirmation of Canterbury DHB's move into state-of-the-art Christchurch Hospital Hagley which will serve the community well for decades to come.

The Ministry of Health is on track to hand over the facility on 10 August 2020. Sterile Services is due to be operational on 31 October 2020 and patients are expected to move into Hagley from 16 to 25 November 2020.

Health Minister Chris Hipkins says while it's been a long wait for people in Canterbury, there were several challenges given the size and complexity of the build.

“This is the largest hospital ever built in New Zealand. Christchurch Hospital Hagley is 62,000 sqm in area with 10 levels, 3,000 rooms and 413 in-patient beds, including purpose-designed spaces for children,” says Chris Hipkins.

“The new $549 million facility has 12 operating theatres which will enable the DHB to perform significantly more surgeries each year. It also has an expanded intensive care unit, state-of-the-art radiology department, acute medical assessment unit, state-of-the-art sterile services area and an expanded emergency department.

“There is a rooftop helipad capable of landing a helicopter while a second helicopter is parked making transfer of patients significantly faster. There is also a link to Christchurch Women’s Hospital.

“The facility is fitted with 129 base-isolators and built to IL4 (Importance Level 4) standards - the highest level for a building designated as an essential facility following a disaster.

“While it’s taken longer than expected to finish the building, it’s been important to ensure the large amount of finishing work, testing and commissioning of the new facility was completed to a high standard.

“I’d like to acknowledge all those who have been involved in delivering this project – from the early design stages through to all the sub-contractors working with CPB and all the staff at the DHB.

“I know everyone is looking forward to seeing the new hospital operational. It’s a fantastic facility which will enable the DHB to continue to deliver high quality care both now and well into the future,” said Chris Hipkins.

Kirsty Doig
Principal Communications Advisor
Ministry of Health
9(2)(a) [redacted]
kirsty.doig@health.govt.nz
www.health.govt.nz

From: Tony.Lloyd@health.govt.nz
To: David Meates
Cc: Michelle.Arrowsmith@health.govt.nz; Tim Lester
Subject: Re: Hagley handover- any recourse to offset costs of delay?[EXTERNAL SENDER]
Date: Sunday, 5 July 2020 6:37:17 PM
Attachments: ATT00001.jpg
ATT00002.png

Thanks David,

I'll respond more fully in the next few days.

Regards

Tony

Tony Lloyd
Programme Director
DHB Performance, Support & Infrastructure
Ministry of Health

133 Molesworth Street
PO Box 5013
WELLINGTON 6011
mailto:from 29/5/19 tony.lloyd@health.govt.nz

From: "David Meates" <David.Meates@cdhb.health.nz>
To: "Michelle.Arrowsmith@health.govt.nz" <Michelle.Arrowsmith@health.govt.nz>, "Tony Lloyd/MOH" <Tony.Lloyd@health.govt.nz>

Cc: "Tim Lester" <Tim.Lester@cdhb.health.nz>
Date: 05/07/2020 04:14 pm
Subject: Hagley handover- any recourse to offset costs of delay?

Michelle / Tony

Please note email below from Tim Lester in which he is responding to question about the ongoing costs being incurred by the DHB with the ongoing delays associated with the completion of Hagley.

Could you please review and respond to the queries that Tim has raised below.

Nga mihi

David Meates, MNZM
Chief Executive | Canterbury District Health Board and West Coast District Health Board
T: 03 364 4110 (ext 62110) | E: david.meates@cdhb.health.nz
P O Box 1600, Christchurch 8140
www.cdhb.health.nz | www.westcoastdhb.org.nz

From: Tim Lester
Sent: Friday, 3 July 2020 5:53 PM
To: David Meates <David.Meates@cdhb.health.nz>
Subject: Hagley handover- any recourse to offset costs of delay?

Hi David

Under the Ministry and CPB Main Construction Contract, the original completion date was specified as 3 July 2018.

The agreement provides that liquidated damages for late delivery are payable at an agreed rate (extract below):

Liquidated damages should represent an agreed pre-estimate of losses likely to be suffered where the contractor fails to achieve PC by the due date. It should include CDHB's costs.

The agreement provides that if, for whatever reason the LDs are unable to be claimed (void, unenforceable etc), then general damages may be claimed against the contractor.

I understand that the contractor is not paying LDs. If that the case then the reasons *may* be:

- the Ministry and Contactor have agreed extensions of time or variations; or
- that the cause of the delay does not sit with the Contractor.

I'm very aware that the DHB is incurring the costs of ongoing delay, without the benefit of LD's/other remedy to offset the losses.

I'm keen to ensure that Ministry and CDHB have have turned our minds to any avenues to offset the mounting costs of delay.

I would like to understand:

1. whether the liquidated damages specified take into account the costs to the DHB of late delivery?
2. whether the liquidated damages prescribed in the Agreement have/are been paid by the Contractor?; and
3. if not so paid, why not? Does responsibility for late delivery of the project lie elsewhere?

The Ministry (as Principal) holds the contracts- and therefore the recourse against any party at fault.

Once the contracts are novated, CDHB steps into the Ministry's shoes (and any rights of recourse).

Do you or the team have any visibility from HRPG? Or shall I pick up with Tony in the first instance?

Happy to discuss

Regards

Tim Lester
Corporate Solicitor
Canterbury District Health Board

T: 03 364 4128 (Internal ext: 62128) | 9(2)(a) | E: tim.lester@cdhb.health.nz
Level 1, 32 Oxford Terrace, Christchurch | PO Box 1600 | Christchurch | www.cdhb.govt.nz.

****

Out of Scope

[redacted]

[redacted]

[redacted]

From: Michelle.Arrowsmith@health.govt.nz
To: Tim Lester
Cc: David Meates; Lester Levy; John Hansen
Subject: RE: Hagley handover- any recourse to offset costs of delay?
Date: Thursday, 23 July 2020 11:54:55 PM
Attachments: ATT00001.jpg
ATT00002.png

Kia Ora Tim

The contract for construction, as you are aware, sits as an agreement between the Crown and the Contractor. Matters pertaining to charging Liquidated Damages in that contract were set based on costs incurred by the project and do not consider the any wider costs that may be incurred by the CDHB. The decision to seek Liquidated Damages or not has been discussed at length both in the Ministry and with the HRPG. At this time there is no immediate decision to seek Liquidated Damages.

The Ministry is continuing to work with CPB to resolve all claims and counter claims, and as you will appreciate, this may take some time and is the reason why a number of the contracts that otherwise would be transferred to the CDHB are being retained by the Ministry. This includes the CPB contract.

The CDHB should make provision for costs incurred within your operating position.

Nga mihi
Michelle

Michelle Arrowsmith
Deputy Director-General
DHB Performance Support & Infrastructure
Ministry of Health
Mobile: 9(2)(a)

From: "Tim Lester" <Tim.Lester@cdhb.health.nz>
To: "Tony Lloyd/MOH" <Tony.Lloyd@health.govt.nz>, "Michelle.Arrowsmith@health.govt.nz" <Michelle.Arrowsmith@health.govt.nz>,
Cc: "David Meates" <David.Meates@cdhb.health.nz>
Date: 22/07/2020 05:10 p.m.
Subject: RE: Hagley handover- any recourse to offset costs of delay?

Hi Tony

Just following up to see when we may expect a response on this?

Happy to discuss.

Thanks

Tim Lester
Corporate Solicitor
Canterbury District Health Board

T: 03 364 4128 (Internal ext: 62128) 9(2)(a) | E: tim.lester@cdhb.health.nz
Level 1, 32 Oxford Terrace, Christchurch | PO Box 1600 | Christchurch | www.cdhb.govt.nz.

From: David Meates
Sent: Sunday, 5 July 2020 4:14 p.m.
To: Michelle.Arrowsmith@health.govt.nz; Tony Lloyd/MOH <Tony.Lloyd@health.govt.nz>
Cc: Tim Lester <Tim.Lester@cdhb.health.nz>
Subject: Hagley handover- any recourse to offset costs of delay?

Michelle / Tony

Please note email below from Tim Lester in which he is responding to question about the ongoing costs being incurred by the DHB with the ongoing delays associated with the completion of Hagley.

Could you please review and respond to the queries that Tim has raised below.

Nga mihi

David Meates, MNZM
Chief Executive | Canterbury District Health Board and West Coast District Health Board
T: 03 364 4110 (ext 62110) | E: david.meates@cdhb.health.nz
P O Box 1600, Christchurch 8140
www.cdhb.health.nz | www.westcoastdhb.org.nz

Values – A Matou Uara
Care and respect for others - Manaaki me te whakaute i te tangata | Integrity in all we do - Hapai i a matou mahi katoa i runga i te pono | Responsibility for outcomes - Te Takohanga i nga hua

From: Tim Lester
Sent: Friday, 3 July 2020 5:53 PM
To: David Meates <David.Meates@cdhb.health.nz>
Subject: Hagley handover- any recourse to offset costs of delay?

Hi David

Under the Ministry and CPB Main Construction Contract, the original completion date was specified as 3 July 2018.

The agreement provides that liquidated damages for late delivery are payable at an agreed rate (extract below):

cid:image002.png@01D66022.A9F77610

Liquidated damages should represent an agreed pre-estimate of losses likely to be suffered where the contractor fails to achieve PC by the due date. It should include CDHB's costs.

The agreement provides that if, for whatever reason the LDs are unable to be claimed (void, unenforceable etc), then general damages may be claimed against the contractor.

I understand that the contractor is not paying LDs. If that the case then the reasons *may* be:

- the Ministry and Contactor have agreed extensions of time or variations; or
- that the cause of the delay does not sit with the Contractor.

I'm very aware that the DHB is incurring the costs of ongoing delay, without the benefit of LD's/other remedy to offset the losses.

I'm keen to ensure that Ministry and CDHB have have turned our minds to any avenues to offset the mounting costs of delay.

I would like to understand:

1. whether the liquidated damages specified take into account the costs to the DHB of late delivery?
2. whether the liquidated damages prescribed in the Agreement have/are been paid by the Contractor?; and
3. if not so paid, why not? Does responsibility for late delivery of the project lie elsewhere?

The Ministry (as Principal) holds the contracts- and therefore the recourse against any party at fault.

Once the contracts are novated, CDHB steps into the Ministry's shoes (and any rights of recourse).

Do you or the team have any visibility from HRPG? Or shall I pick up with Tony in the first instance?

Happy to discuss

Regards

Tim Lester
Corporate Solicitor
Canterbury District Health Board

T: 03 364 4128 (Internal ext: 62128) | M 9(2)(a) | E: tim.lester@cdhb.health.nz
Level 1, 32 Oxford Terrace, Christchurch | PO Box 1600 | Christchurch | www.cdhb.govt.nz.

From: Karen.Anslow@health.govt.nz on behalf of Ashley.Bloomfield@health.govt.nz
To: David Meates
Cc: "Ashley.Bloomfield@health.govt.nz"; "Michelle.Arrowsmith@health.govt.nz"; Shayne.Hunter@health.govt.nz; Stella Ward; Susan Fitzmaurice
Subject: RE: Letter regarding NBRS and NPF data issues
Date: Friday, 31 July 2020 9:46:27 AM
Attachments: ATT00001.jpg
ATT00002.jpg

Kia ora David,

I've asked Shayne Hunter to engage with CPHB team on the issues raised.

Kind regards
Ashley

Dr Ashley Bloomfield
Director-General of Health

email: ashley.bloomfield@health.govt.nz
Mobile: 9(2)(a) [redacted]
www.health.govt.nz

From: "David Meates" <David.Meates@cdhb.health.nz>
To: "'Ashley.Bloomfield@health.govt.nz'" <Ashley.Bloomfield@health.govt.nz>
Cc: "Shayne.Hunter@health.govt.nz" <Shayne.Hunter@health.govt.nz>, "Stella Ward" <Stella.Ward@cdhb.health.nz>, "'Michelle.Arrowsmith@health.govt.nz'" <Michelle.Arrowsmith@health.govt.nz>
Date: 30/07/2020 11:05 am
Subject: RE: Letter regarding NBRS and NPF data issues
Sent by: "Susan Fitzmaurice" <Susan.Fitzmaurice@cdhb.health.nz>

Good morning Ashley

Please find attached response from David Meates to your letter regarding NBRS and NPF data issues

Regards

Susan Fitzmaurice | EA to David Meates, Chief Executive
Canterbury District Health Board and West Coast District Health Board

03 364 4110 | susan.fitzmaurice@cdhb.health.nz
P O Box 1600, Christchurch
www.cdhb.health.nz | www.westcoastdhb.org.nz

[redacted] [redacted]

Values – A Matou Uara
Care and respect for others - Manaaki me te whakaute i te tangata | Integrity in all we do - Hapai i a matou mahi katoa i runga i te pono | Responsibility for outcomes - Te Takohanga i nga hua

From: Paula.Steven@health.govt.nz [mailto:Paula.Steven@health.govt.nz] **On Behalf Of** Michelle.Arrowsmith@health.govt.nz
Sent: Tuesday, 21 July 2020 7:10 p.m.
To: David Meates <David.Meates@cdhb.health.nz>
Cc: Shayne.Hunter@health.govt.nz; Matthew Long <Matthew.Long@cdhb.health.nz>
Subject: Letter regarding NBRS and NPF data issues

Tena koe David
Please see attached letter to request resolution of data issues with waiting time reporting. This plan should be submitted by 31 August 2020.
If you have any concerns, please contact either myself or Shayne Hunter on Shayne.Hunter@health.govt.nz

Nga mihi
Michelle

Michelle Arrowsmith
Deputy Director-General
DHB Performance Support & Infrastructure
Ministry of Health
Mobile: 9(2)(a) [redacted]
****

From: Jo.Waugh@health.govt.nz on behalf of Ashley.Bloomfield@health.govt.nz
To: David Meates
Subject: Re: Resignation of Michael Frampton, Chief People Officer[EXTERNAL SENDER]
Date: Tuesday, 21 July 2020 5:21:25 PM
Attachments: ATT00001.jpg

Thanks David for letting us know.

Kind regards
Ashley

Dr Ashley Bloomfield
Director-General of Health

email: ashley.bloomfield@health.govt.nz
Mobile: 9(2)(a)
www.health.govt.nz

From: "David Meates" <David.Meates@cdhb.health.nz>
To: "'Ashley.Bloomfield@health.govt.nz'" <Ashley.Bloomfield@health.govt.nz>, "'Anna.Clark@health.govt.nz'" <Anna.Clark@health.govt.nz>
Date: 20/07/2020 11:08 am
Subject: Resignation of Michael Frampton, Chief People Officer
Sent by: "Susan Fitzmaurice" <Susan.Fitzmaurice@cdhb.health.nz>

FYI the announcement below was sent to all staff today

It is with regret I advise that Michael Frampton has resigned from his role as Chief People Officer, Canterbury DHB and West Coast DHB.

Michael came to health eight years ago this month. He was responsible for leading change across the West Coast Health System, and driving the process to secure commitment for a new hospital in Greymouth. (Coincidentally, from next week patients begin moving into the new Te Nikau Grey Hospital.)

Subsequently, Michael moved to Canterbury to lead the transformation and reinvention of HR. Today, our People and Capability team has new strategy, new people with new and different perspectives, experience and talent, it delivers new services supported by new technology, and it's realising a completely different kind of value. Michael has inspired and led this work, and established the foundations for the ongoing journey we are on to put our people at the centre of everything we do.

To Michael, I want to say this. Being at the leading edge of transformation in the HR space is both one of the most challenging endeavours in any health organisation but also one of the most rewarding. Thank you for all that you have contributed and given to make *Our Health System* better - you have made a real and lasting difference.

Michael is returning home to Auckland and taking up the role of Chief People Officer with Sky. On behalf of the Board and EMT, I acknowledge Michael's tremendous contribution to both the Canterbury and West Coast Health Systems and wish him every success for his new role.

Michael's last working day is Friday 28 August 2020.

Nga mihi

David Meates, MNZM
Chief Executive | Canterbury District Health Board and West Coast District Health Board
T: 03 364 4110 (ext 62110) | E: david.meates@cdhb.health.nz
P O Box 1600, Christchurch 8140
www.cdhb.health.nz | www.westcoastdhb.org.nz

From: Tony.Lloyd@health.govt.nz
To: David Meates
Cc: 9(2)(a) ; Karl.Wilkinson@health.govt.nz
Subject: Valves - Hagley[EXTERNAL SENDER]
Date: Friday, 24 July 2020 11:57:46 AM

David,

The cause of the valve failure was probably over-tightening of the valve into the valve assembly at the factory. This is the first impression of the independent tester. The valve had been in situ and in service under pressure for at least 12 months.

We have 670 of these types of valves in the building (the 900 related to all types of valves). As yet I do not know how many of the 670 are from this particular batch.

CPB have undertaken a visual check of a random sample of installed valves and have not found any displaying signs of deterioration.

81 of these valves are located above clinical spaces, beds, computer rooms, DSA, treatment rooms and the hybrid theatre. The balance are in corridors and non clinical spaces.

Of the 81 valves, we are assessing how many are from this batch.

All 81 valves in these areas are accessible by access hatch.

I have instructed CPB to conduct a visual inspection of all valves in areas where valves are located above clinical spaces, beds, computer rooms, DSA, treatment rooms and the hybrid theatre. Once this is completed, we will inspect the balance of the valves.

Should only the valve itself, rather than the full assembly, require to be changed, it can be isolated at the unit and changed simply. To change a valve is a quick and relativity minor process and does not involve dirty works.

Availability of valves. It is a three week lead time for manufacture and if we allow two weeks for freight they will be here in early September.

Should it be deemed necessary, VAE, the installers have advised they can change out the 81 valves using four teams. Each valve is an hour's work - 20 hours total (allow four days). This can be done either during the day or at night if that creates less disruption.

Regards

Tony

Tony Lloyd
Programme Director
DHB Performance, Support & Infrastructure
Ministry of Health

133 Molesworth Street
PO Box 5013
WELLINGTON 6011
mailto:from 29/5/19 tony.lloyd@health.govt.nz
****

attachments may contain information that is IN-CONFIDENCE and subject to legal privilege.
If you are not the intended recipient, do not read, use, disseminate, distribute or copy this message or attachments.
If you have received this message in error, please notify the sender immediately and delete this message.
****

From: Jessica.Smaling@health.govt.nz
To: Carolyn Gullery; Justine White; David Meates
Subject: Whakaari/White Island funding
Date: Thursday, 2 July 2020 1:45:17 PM

Hi David, Carolyn, Justine

Just a brief email to let you know that joint Ministers of ACC and Health have now signed off the PHAS variation for additional funding for DHBs relating to direct costs associated with treating people injured during the Whakaari/White Island eruption.

Additional funding of $1,106,829 will be made to Canterbury DHB for this purpose, via the August DHB Cash Profile payment.

Thank you to your team for engaging closely on this process, and for your patience while we progressed the agreement.

Let me know if you have any questions.

Kind regards
Jess

Jess Smaling
Group Manager, DHB Planning, Funding & Accountability
DHB Performance, Support & Infrastructure
Ministry of Health, 133 Molesworth Street, Thorndon, PO Box 5013, Wellington 6140
9(2)(a) ; http://www.moh.govt.nz
mailto:Jessica.Smaling@health.govt.nz

Kathleen Smitheram

From: Paula.Steven@health.govt.nz on behalf of Michelle.Arrowsmith@health.govt.nz
Sent: Wednesday, 8 July 2020 12:35 PM
To: David Meates
Cc: Justine White; Fergus.Welsh@health.govt.nz; Lester Levy (lester.levy@[redacted] John Hansen
Subject: Canterbury DHB and Earthquake Insurance Proceeds Drawdown 070720
Attachments: Canterbury DHB and Earthquake Insurance Proceeds Drawdown 070720.pdf

Kia ora David

Please see attached letter regarding whether capital charge is payable upon the drawdowns of the insurance proceeds from the Canterbury earthquake in 2011.

Ngā mihi
Michelle

Michelle Arrowsmith
Deputy Director-General
DHB Performance Support & Infrastructure
Ministry of Health
Mobile: [redacted]

133 Molesworth Street
PO Box 5013
Wellington 6140
New Zealand
T+64 4 496 2000

Mr David Meates
Chief Executive
Canterbury District Health Board
david.meates@cdhb.govt.nz

Dear David

Canterbury DHB and Earthquake Insurance Proceeds Drawdown

I am writing to you in connection with the discussions that have been occurring over the last 18 months between yourselves and the Ministry of Health (the Ministry) regarding whether capital charge is payable upon the drawdowns of the insurance proceeds from the Canterbury earthquake in 2011. This was discussed at your performance meeting in June.

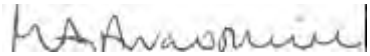
The insurance proceeds were received by Canterbury District Health Board (CDHB) in 2012 and were transferred to the Crown at that point so that CDHB's assets were not inflated by the full value of the proceeds from that point onwards, when the assets that these insurance proceeds related to were still in a state of disrepair. This, in turn, ensured that CDHB did not incur any additional capital charges in relation to these received funds.

As the work progressed to rectify these assets, the funds were drawn down from the Crown in the same way as they would have been had they been part of a "normal" capital rebuild programme of work. Therefore, the DHB increased the value of the assets that it holds on behalf of the Crown. Bringing it in line with the principles of the capital charging mechanism, annual capital charges are payable upon the value of the funds invested in CDHB, as governed by the net assets.

The key decision here is whether these drawdowns are determined as being "gifted" funds to the DHB. It is the assertion of the Ministry that these funds would not be classified as gifted assets as they are drawn down, as they are funds being used to return assets back to their pre-earthquake state. In other words, the Crown's assets managed by the DHB were devalued in the earthquake and are now being restored back to their prior levels. For the Crown, there has been no repayment made of the amount of equity invested in CDHB, but there has been a reduction in the amount of capital charge payable by CDHB over the period from 2012 to 2020, due to the reduced value of the assets.

On this basis, we require that CDHB pay capital charge on the value of the drawdowns form the earthquake insurance proceeds. This will mean making catch up payments for the capital charge invoices from June 2019, December 2019 and June 2020. Please make this payment to the Ministry as soon as possible in order to bring this matter to a conclusion.

Yours sincerely



Michelle Arrowsmith
Deputy Director-General, DHB Performance Support and Infrastructure
Ministry of Health

Cc: Justine White, CFO Canterbury DHB
Fergus Welsh, CFO, Ministry of Health
Lester Levy, Crown Monitor Canterbury DHB
Sir John Hansen, Board Chair Canterbury DHB

From: Paula.Steven@health.govt.nz on behalf of Michelle.Arrowsmith@health.govt.nz
To: David Meates
Subject: Feedback for the final draft 2020/21 annual plans and process to finalise the plans[EXTERNAL SENDER]
Date: Tuesday, 14 July 2020 2:10:49 PM
Attachments: Canterbury DHB.pdf

Tena koe David

Feedback for the final draft 2020/21 annual plans and process to finalise the plans

We appreciate the time and effort that has gone into the 2020/21 planning process.

Last Thursday feedback was provided to your planning team on your final draft plan, and a high-level summary of the feedback is attached to this e-mail for your information.

As you know, Ministers requested approval process are fast-tracked from this point, and all Boards are asked to have their plans in a position to be put forward for Ministerial approval during August.

On that basis, we all need to meet very tight timeframes. The process that we are working to is:

- DHBs are asked to address all remaining issues identified and send a final annual plan for a last check ahead of your Board approval process (to annualplan@health.govt.nz) by **Friday 17 July.**
- The Ministry will provide fast turn-around feedback to you should there be any issues that need to be resolved.
- DHBs are to finalise plans, with Board sign-off expected to occur from the end of July.
- Please then supply your Board approved plan to the Ministry. The Ministry will submit DHB plans for Ministerial approval in August.

We appreciate that this is a pressured timeline for everyone. To support you to meet these timeframes the DHB quarter 4 non-financial reporting date is further extended, with reports now due on Friday 14 August.

I also remind you that your Statement of Performance Expectations (and Statements of Intent if applicable) are to be published on your website by 15 August.

Thank you again.

Nga mihi
Michelle

Michelle Arrowsmith
Deputy Director-General
DHB Performance Support & Infrastructure
Ministry of Health
Mobile: 9(2)(a)

****

****

Canterbury DHB

Final Draft Feedback Heatmap

	Approved		Approved technical issues - requires minor updates		Declined -further work required

1.1.1 Strategic Intentions/Priorities/Outcomes	
2.1.1 Engagement and Obligations as a Treaty Partner	
2.1.2 Māori Health Action Plan - Accelerate the spread and delivery of Kaupapa Māori services	
2.1.3 Māori Health Action Plan - Shifting cultural and social norms	
2.1.4 Māori Health Action Plan - Reducing health inequities - the burden of disease for Māori	
2.1.5 Māori Health Action Plan - Strengthening system settings	
2.2.1 Improved out year planning processes	
2.2.2 Savings plans - in-year gains	
2.2.3 Savings plans - out year gains	
2.2.4 Working with sector partners to support sustainable system improvements	
2.3.1 Maternity and Midwifery workforce	
2.3.2 Maternity and early years	
2.3.3 SUDI component	
2.3.4 Immunisation	
2.3.5 School-based health services	
2.3.6 Family Violence and Sexual Violence	
2.4.1 Mental Health and Addiction System Transformation	
2.4.2 Mental health and addictions improvement activities	
2.4.3 Addiction	
2.4.4 Maternal mental health services	

2.4.5 Mental health support in earthquake affected schools (Canterbury DHB only)	
2.5.1 Environmental sustainability	
2.5.10 Sexual health	
2.5.11 Communicable Diseases	
2.5.12 Cross Sectoral Collaboration including Health in all Policies	
2.5.2 Antimicrobial Resistance (AMR)	
2.5.3 Drinking water	
2.5.4 Environmental and Border Health	
2.5.5 Healthy food and drink	
2.5.6 Smokefree 2025	
2.5.7 Breast Screening	
2.5.8 Cervical Screening	
2.5.9 Reducing alcohol related harm	
2.6.1 Delivery of Whānau Ora	
2.6.10 Improving Quality	
2.6.11 New Zealand Cancer Action Plan 2019-2029	
2.6.12 Bowel screening and colonoscopy wait times	
2.6.13 Workforce	
2.6.14 Data and Digital	

2.6.15 Implementing the New Zealand Health Research Strategy	
2.6.16 Delivery of Regional Service Plan priorities and relevant national service plans	
2.6.2 Pacific Health Action Plan	
2.6.3 Care Capacity Demand Management	
2.6.4 Disability Action Plan	
2.6.5 Disability	
2.6.6 Planned Care	
2.6.7 Acute Demand	
2.6.8 Rural Health	
2.6.9 Healthy ageing	
2.7.1 Primary health care integration	
2.7.2 Pharmacy	
2.7.3 Long-term conditions including diabetes	
2.7.4 Air Ambulance centralised tasking	
3.1.1 Service Coverage	
3.1.2 Service change	
4.1.1 Managing our business	
4.1.2 Building capability	
5.1.1 Performance measures	

Kathleen Smitheram

From: Paula.Steven@health.govt.nz on behalf of Michelle.Arrowsmith@health.govt.nz
Sent: Thursday, 16 July 2020 5:08 PM
To: David Meates
Cc: Astuti.Balram@health.govt.nz
Subject: National Critical Care Service Planning - Health Infrastructure Unit Workshop[EXTERNAL SENDER]
Attachments: David Meates - Canterbury DHB Letter.pdf

Kia ora David

Please see attached letter with regards to a virtual meeting on Wednesday, 29 July 2020 to discuss development of a national critical care service plan in partnership with the sector.

If you have any questions, please contact Astuti Balram –Manager, Service Planning, Capital Investment Management: Astuti.Balram@health.govt.nz

Ngā mihi
Michelle

Michelle Arrowsmith
Deputy Director-General
DHB Performance Support & Infrastructure
Ministry of Health
Mobile: 9(2)(a) **********

133 Molesworth Street
PO Box 5013
Wellington 6140
New Zealand
T+64 4 496 2000

16 July 2020

David Meates
Chief Executive
Canterbury / West Coast District Health Board
david.meates@cdhb.govt.nz

Dear David

National Critical Care Service Planning – Health Infrastructure

The Ministry of Health (MOH) would like to develop a national critical care service plan in partnership with the sector. Critical care services are crucial for people with the most complex acute health care needs. Critical care services are also key components of capital investment business cases and service planning for critical care has been identified as a priority by the MOH's Health Infrastructure Unit (HIU). We seek the support of the National CE's Group in progressing the National Critical Care Service Planning programme.

National service planning for critical care will build on local and regional developments. There have been several intensive care related strategies, reviews and planning processes undertaken by the sector. DHBs and regions continue to plan for critical care services within their geographies. More recently, the sector demonstrated its ability to respond quickly to support the potential surge in critical care demand that COVID-19 could have generated. National service planning will play a crucial role in connecting developments for a future ready critical care system across New Zealand.

The critical care service planning will take a long-term view of 10-15years. It is acknowledged that models of care and service delivery will evolve during this time, however a long-term view is essential to enable effective infrastructure planning. The goal will be to deliver a service plan, supported by the sector, by the end of 2021.

The national approach to critical care service planning will require strong sector engagement and support. The HIU will seek sector leadership through the governance process, participating in workstreams, sharing of information to support planning and agreement to align with a nationally agreed service plan.

We are aiming to host a virtual initiation meeting on Wednesday, 29 July 2020 with key partners. We have sought COO representation and GM P&F representation through the national groups. Other attendance will include clinical leaders from across NZ, Māori Health, workforce and MOH representatives. Subsequent to this initiation meeting, we will establish the National Critical Care Service Planning Steering Group to progress the work programme.

If you have any questions, please contact Astuti Balram –Manager, Service Planning, Capital Investment Management: Astuti.Balram@health.govt.nz or Andy Simpson, Chief Medical Officer: Andrew.Simpson@health.govt.nz. We look forward to working with you.

Yours sincerely

Michelle Arrowsmith
Deputy Director-General
Ministry of Health

Kathleen Smitheram

From: Paula.Steven@health.govt.nz on behalf of Michelle.Arrowsmith@health.govt.nz
Sent: Tuesday, 21 July 2020 7:10 PM
To: David Meates
Cc: Shayne.Hunter@health.govt.nz; Matthew Long
Subject: Letter regarding NBRS and NPF data issues
Attachments: Canterbury DHB.pdf

Tēnā koe David
Please see attached letter to request resolution of data issues with waiting time reporting. This plan should be submitted by 31 August 2020.
If you have any concerns, please contact either myself or Shayne Hunter on Shayne.Hunter@health.govt.nz

Ngā mihi
Michelle

Michelle Arrowsmith
Deputy Director-General
DHB Performance Support & Infrastructure
Ministry of Health
Mobile: 9(2)(a) [redacted]
****

****

133 Molesworth Street
PO Box 5013
Wellington 6140
New Zealand
T+64 4 496 2000

David Meates
Chief Executive
Canterbury District Health Board

david.meates@cdhb.govt.nz

Tēnā koe David

Resolution of data issues with waiting time reporting

The recent COVID-19 pandemic has reinforced the need for both the Ministry of Health and the wider health sector to have timely and accurate data and information available to help ensure that both patient safety and efficient care are being delivered within our health system.

Within the Operational Policy Framework (OPF) all DHBs have an obligation to provide accurate and timely information to national collections. Having accurate information available is now even more important as the health system works to recover from the COVID-19 disruption to planned care services. Both the National Booking Reporting System (NBRS) and National Patient Flow (NPF) are essential in understanding how effectively the health system responds to this pandemic.

National Booking Reporting System (NBRS)

I am concerned that, although it is over two years since the implementation of the SIPICs, the data issues that arose as a result of this upgrade have still not been completely resolved and the data corrected. Until we are confident in the processes around the SIPICs implementation, migration, and data quality validation we do not believe it is appropriate to further roll out SIPICs to the remaining regional DHBs.

I acknowledge that your DHB is working with the Ministry to address some of the historic data issues, and good progress has been made in the last few months. However the reporting issues you are experiencing have persisted for some time. I expect that all remaining NBRS data issues will be resolved by **31 October 2020.**

If you do not believe you can meet this expectation, it would be appreciated if you could provide a summary of actions underway to correct your data, any outstanding issues or challenges, and a timeframe for when you will have resolved all the remaining issues.

National Patient Flow (NPF)

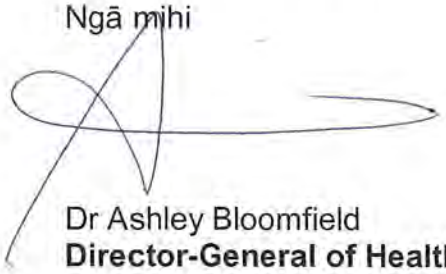
While we continue to provide updates and a comparison to the other national collections through the quarterly reporting process, I am concerned about the limited number of DHBs that are reporting all mandatory data fields and services to NPF. It is particularly concerning that most DHBs still do not accurately report radiology, cancer, diagnoses, presenting problems, or linking elements nearly six years after the collection commenced. I expect that all DHBs begin submitting data to NPF more frequently and that all remaining data issues within NPF are resolved by 31 December 2020.

It would be appreciated if your DHB could submit a plan on how you intend to begin submission of the remaining elements of the NPF collection. This plan should be submitted to npfadmin@health.govt.nz by **31 August 2020.**

The Ministry would be happy to provide support from our Data and Digital and DHB Performance Support and Infrastructure (DHB PSI) directorates to help address any issues.

If you have any concerns regarding the above, please contact either myself, Shayne Hunter or Michelle Arrowsmith.

Ngā mihi



Dr Ashley Bloomfield
Director-General of Health

cc DHB CIOs
Shayne Hunter, Deputy Director-General, Data and Digital
Michelle Arrowsmith, Deputy Director-General, DHB PSI

From: Jason.Moses@health.govt.nz
To: David Meates; Hector Matthews
Subject: Re: Wai 2575 - Questions for Canterbury DHB
Date: Wednesday, 29 July 2020 11:14:48 AM
Attachments: Document with questions to Canterbury DHB from stage two disability claims.docx
MoH Treaty Position Statement.pdf
King - B22 - Maori with lived experience of disability part 1 - summary.pdf

Mo taku he (apologies). Below are two further attachments that should have been included in my email.

Jason Moses
Manager Maori Crown Relations
Maori Health Directorate
Ministry of Health
Located at: Level 1 North, Green, 133 Molesworth Street, Wellington View Address
9(2)(a) [redacted]

From: Jason Moses/MOH
To: david.meates@cdhb.govt.nz, hector.matthews@cdhb.govt.nz
Cc: John Whaanga/MOH@MOH, Sharlene Tanirau/MOH@MOH, "Abbey Lawson" <Abbey.Lawson@crownlaw.govt.nz>, "Zoe Rose-Curnow (zoe.rose-curnow@craiglinkhorn.com)" <zoe.rose-curnow@craiglinkhorn.com>, Louise Kuraia/MOH@MOH
Date: 29/07/2020 10:27 am
Subject: Wai 2575 - Questions for Canterbury DHB

Tena korua e aku rangatira
Tena korua i runga i nga tini aitua o te wa nei; e hinga mai nei, e hinga atu ra. Ko ratau ki a ratau; ko tatau ki a tatau. Tena ano tatau katoa!
As you are aware, the Waitangi Tribunal's Health Services and Outcomes Kaupapa Inquiry (Wai 2575) will hear claims concerning grievances relating to health services and outcomes which are of national significance. The Tribunal is in stage two of this inquiry. Stage two will cover three priority areas: Maori with disabilities, Maori mental health (including suicide and self-harm), and issues of alcohol, tobacco, and substance abuse for Maori. The Tribunal has selected Maori with disabilities to inquire into first. The Tribunal has received upwards of 40 disability related statements of claim from claimants seeking to participate in this part of stage two.
In the attached document we are seeking information from Canterbury District Health Board (DHB) to help the Crown respond to claims about Maori with disabilities living in the Canterbury DHB region that have been made in this part of the Wai 2575 inquiry. We ask you to review the allegations of fact in each claim that relate to Canterbury DHB. Your responses will assist the Crown to respond to each of the claims; and prepare for later stages of the inquiry, which will include discovery and the filing of evidence, and the hearings. We may need to collaborate with you further when we reach these stages. In relation to responses to each of the claims, it would be very helpful if you could provide us a response in the next 4 weeks.
Also, in the attached document, we also ask you to review the conclusions made about Canterbury DHB in one of the research reports commissioned by the Waitangi Tribunal. In relation the issues raised in the research report, it would be very helpful if you could provide us a response to the report in the next 10 weeks.

Thank you in advance. We look forward to receiving your responses.
Na reira, tena ano korua i runga i te mohio kei te anga whakamua tatou i tenei kaupapa.
Naku noa, na

Jason Moses
Manager Maori Crown Relations
Maori Health Directorate
Ministry of Health
Located at: Level 1 North, Green, 133 Molesworth Street, Wellington View Address
9(2)(a)
[redacted]

MINISTRY OF HEALTH
MANATŪ HAUORA

Te Tiriti o Waitangi Position Statement

Purpose

As a Department of the Public Service, the Ministry of Health has a responsibility to contribute to the Crown meeting its obligations under Te Tiriti o Waitangi / The Treaty of Waitangi (Te Tiriti). This statement confirms our commitment and provides high-level direction for how we will go about delivering on it.[1]

Our expression of Te Tiriti

The text of Te Tiriti, including the preamble and the three articles, along with the Ritenga Māori declaration,[2] are the enduring foundation of our approach. Based on these foundations, we will strive to achieve the following four goals, each expressed in terms of mana:[3]

- **Mana whakahāere:** effective and appropriate stewardship or kaitiakitanga over the health and disability system. This goes beyond the management of assets or resources.
- **Mana motuhake:** Enabling the right for Māori to be Māori (Māori self-determination); to exercise their authority over their lives, and to live on Māori terms and according to Māori philosophies, values and practices including tikanga Māori.
- **Mana tangata:** Achieving equity in health and disability outcomes for Māori across the life course and contributing to Māori wellness.
- **Mana Māori:** Enabling Ritenga Māori (Māori customary rituals) which are framed by te ao Māori (the Māori world), enacted through tikanga Māori (Māori philosophy & customary practices) and encapsulated within mātauranga Māori (Māori knowledge).

Our approach to achieving these goals

The principles of Te Tiriti o Waitangi, as articulated by the Courts and the Waitangi Tribunal, provide the framework for how we will meet our obligations under Te Tiriti in our day-to-day work. The 2019 Hauora report recommends the following principles for the primary health care system.[4] These principles are applicable to wider health and disability system. The principles that apply to our work are:

- **Tino rangatiratanga:** The guarantee of tino rangatiratanga, which provides for Māori self-determination and mana motuhake in the design, delivery, and monitoring of *health and disability services*.

[1] Further detail can be found in the Cabinet Office circular CO (19) 5 Te Tiriti o Waitangi/Treaty of Waitangi Guidance 22 October 2019
[2] Often referred to as the 'fourth article' or the 'verbal article'
[3] Mana is a uniquely Māori concept that is complex and covers multiple dimensions.
[4] Waitangi Tribunal. 2019. Hauora: Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry. Wellington. Waitangi Tribunal. pp. 163-164

- **Equity:** The principle of equity, which requires the Crown to commit to achieving equitable health outcomes for Māori.
- **Active protection:** The principle of active protection, which requires the Crown to act, to the fullest extent practicable, to achieve equitable health outcomes for Māori. This includes ensuring that it, its agents, and its Treaty partner are well informed on the extent, and nature, of both Māori health outcomes and efforts to achieve Māori health equity.
- **Options:** The principle of options, which requires the Crown to provide for and properly resource kaupapa Māori *health and disability services*. Furthermore, the Crown is obliged to ensure that all *health and disability services* are provided in a culturally appropriate way that recognises and supports the expression of hauora Māori models of care.
- **Partnership:** The principle of partnership, which requires the Crown and Māori to work in partnership in the governance, design, delivery, and monitoring of *health and disability services*. Māori must be co-designers, with the Crown, of the primary health system for Māori.

Meeting our obligations under Te Tiriti is necessary if we are to realise the overall aim of Pae Ora (healthy futures for Māori) under He Korowai Oranga (the Māori Health Strategy).

Dr Ashley Bloomfield
Director-General of Health

Date: 9/1/2020

9(2)(a) [redacted]

CLIFTONCHAMBERS

Wai 2575 – health services and outcomes kaupapa inquiry - disability phase

Summary of research report "Māori with Lived Experience of Disability (Part 1)" (Wai 2575, B22) authored by Dr Paula King

Purpose

1. This document has been prepared to serve as a summary of the research report prepared by Dr Paula King for the disability phase of stage two of the Wai 2575 inquiry.[1] The report is titled "Māori With Lived Experience of Disability (Part 1)".

2. The purpose of this summary document is to assist readers to gain an easy overview of this research and to help readers navigate the research report for issues where more detail is needed.

Structure

3. This summary is structured by chapter. The report is approximately 500 pages.

4. This summary first provides a brief overview of what the chapter is about.

5. The summary then outlines the main points from each chapter, keeping in mind the scope of the disability phase of the stage two inquiry. Page references for quick reference to the body of the report and for further reading on the author's analysis and critique are provided.

Questions posed in commissioning this research

(a) What key historical developments have contributed to the current system of government disability services for Māori and to Māori experiences and attitudes to disability services?

(b) How does the contemporary health system, including legislation, policies and practices recognise and provide for the needs of Māori with disabilities? To what extent, if any, do implementation and outcomes diverge from policy objectives?

(c) To what extent have Māori had opportunities to contribute to relevant policy and legislative developments?

(d) To what extent does disability policy and practice provide culturally appropriate disability services and treatment for those Māori who require it, or provide for Māori-led and developed systems and methods of disability care/kaupapa Māori?

(e) What barriers, if any, do Māori experience in accessing disability services and what are existing Crown policies and practices for recognising and addressing any such barriers?

(f) To what extent have Crown acts or omissions, if any, contributed to disparities in disability services and outcomes between Māori and non-Māori and how are these recognised and addressed?

(g) How effective is current monitoring and data collection for identifying and addressing any disparities in disability services and outcomes for Māori?

[1] Summary prepared May 2020.

L2, Solnet House, 70 The Terrace
PO Box 10731, Wellington 6143
New Zealand
9 [redacted] 9 [redacted]@cliftonchambers.co.nz www.cliftonchambers.co.nz
9(2)(a) [redacted]

Introduction and statistics

Main points

6. Within Te Ao Māori cosmogonies and cosmologies, to be kāpō Māori was a sign of greatness. This was because these people were not reliant on all their senses and had high levels of ability across the senses that they did possess.[2]

7. Māori holistic concepts of health and well-being contrast with individualistic Western worldviews of disability that tend to focus on impairment and reduced functioning.[3]

8. Indigenous people have had different lived experiences to that of non-indigenous people due to the historical and contemporary impacts of colonisation.[4]

9. Current concepts and definitions of disability used by the Crown are not consistent and vary across Crown organisations.[5] For instance, broad definitions of society as disabling differ from definitions used to obtain State support and resources.

10. The author presents an overview of ten western conceptual models of disability which have evolved over time.[6]

11. Core disability statistics are considered in an equity context.

12. The prevalence of disability is higher for Māori than non-Māori. Māori have higher proportions of disability across all age groups and are more likely to experience disability 12 months after an injury.[7]

> For further information, comments around 'Disability statistics for Māori' have been added to a copy of the original report and collated in a "Disability Data Notations" document. Sources of statistics are highlighted, including the year they are taken from, and if they have been age standardised. Different approaches to age standardisation are a limitation on research in this area.

13. Predictors of disability for Māori who have been injured are; two or more chronic conditions; trouble accessing healthcare services; hospitalisation due to injury; and inadequate household income.[8]

14. Māori adults with lived experience of disability were more likely to have multiple impairments compared with non-Māori adults.[9]

15. The top three types of impairment for Māori were mobility impairment (12%), hearing impairment (8%), and at third equal were three types namely agility impairment, difficulty with learning or psychiatric impairment (7% each).[10]

---

2 Page 3.
3 Page 4.
4 Pages 4, 5.
5 Pages 6-8.
6 Pages 11-17. Tragedy/charity, religious/moral, medical, expert/professional, rehabilitation, economic, social, social adapted (to feature elements of the medical model), customer/empowering and rights-based models.
7 Page 20.
8 Page 20.
9 Page 21.
10 Page 22.

16. Four impairment types were significantly more likely to be experienced by Māori than non-Māori. These were difficulty with learning, psychological impairment, difficulty with speaking and intellectual disability.[11]

17. The most common causes of impairment with lived experience of disability were disease or illness (40%), then accident or injury (28%), then conditions existing since birth (24%) and ageing (18%).[12]

18. The proportion of employed working-age people within the Māori population is much lower for Māori with lived experience of disability (44% compared with 68%).[13]

19. Māori with lived experience of disability were more likely to have lower incomes than Māori without lived experience of disability.[14]

20. Within the Māori population, 41% of Māori with lived experience of disability had no formal educational qualifications compared with 24% of Māori without lived experience of disability.[15]

21. Māori with lived experience of disability were more likely to have been victims of violent crime than Māori adults without lived experience of disability (8% compared with 3%).

It is unclear from the report where the statistics to demonstrate unmet need are from, and from what year they are calculated. The reference points to B24 but the proportions cited do not appear to be cited in that report. Other cross-referencing difficulties may become apparent. For example, proportions of unmet need by age group for special equipment in B24 do not appear to match cited comparisons in this report.

Referencing from this report to research relied on can be difficult if pinpoint or page references to material relied on are not supplied or no citation is given for reliance on other work.

22. Experience of discrimination in the past 12 months was more common among Māori with lived experience of disability than Māori (23% compared with 13%).[16]

23. Feelings of loneliness were higher and overall life satisfaction was lower for Māori with lived experience of disability than for Māori.[17]

24. Despite having higher prevalence of disability, when Māori with lived experience of disability are compared with non-Māori, the former have higher proportions of unmet need for access to health professionals and special equipment.[18]

25. The client base for disability support services (DSS) in 2016 comprised 17.5% Māori, 4% with no ethnicity specified and 78.5% non-Māori.[19]

[11] Page 23.
[12] Page 23, 24.
[13] Pages 23-24.
[14] Page 25.
[15] Page 25.
[16] Page 26.
[17] Page 27.
[18] Pages 27, 28.
[19] Page 29.

26. Reasons for the level of unmet need are suggested as; organisational, cost associated and/or lack of rural services and funding for those services.[20]

The author states at page 29 that "The proportion for Maori with lived experience of disability had increased from 16.5 per cent in 2013." The cited report *Demographic Report of Clients allocated the Ministry of Health's Disability support Services*: As at Sept 2016 says that there has been "an increase in Māori DSS Clients, from 16.2% to 17.5% (an 18% increase)". The figure 16.5 % is found nowhere in the cited report and an increase in clients is not the same as an increase in Maori with lived experience with disability.

In addition – at page 29 the author takes issue with the cited report saying Maori are somewhat overrepresented in their client group. The report states that it is "just as likely that Māori are under-represented in the DSS client group, as their access to DSS (17.5 per cent) is disproportionate to need according to the higher prevalence of disability for Māori." This may be correct (under-servicing), but equally reliant on poor statistical analysis at this point given other factors such as DHB provision. More consideration is required.

Chapter one – theoretical approach and research methods

27. This chapter discusses the methods used to prepare this report.

Main points

28. The author's approach is underpinned by kaupapa Māori theory, and the research utilised a mixed methods approach (quantitative and qualitative) of data collection and analysis.[21]

29. The purpose of this research is to examine the historical and contemporary issues relevant to Māori with lived experience of disability, in order to address the research questions, set out by the Waitangi Tribunal.[22]

30. The scope of the research is the examination and analysis of primary and secondary data sources. It does not draw directly upon qualitative interviews/thematic analyses of interviews - this is done in the Kaiwai and Allport Part 2 report commissioned by the Tribunal.[23]

31. There were limits in the literature review attempted because there is very limited information to be found about Māori with lived experience of disability in Te Ao Tawhito.[24]

32. The report provides a lengthy description of the process followed to formulate, administer and deal with information provided and withheld by attempting to conduct this research using the Official Information Act. Among many issues reported was resistance encountered from some Crown organisations to providing information requested.[25]

33. Crown organisations with similar roles approached the same questions in different ways, particularly amongst responses from DHBs. Some were helpful, others were not.[26]

The report's section discussing the rationale and attempts to use the OIA process as a research tool and the conflicting approach by respondents to providing information in response to questions posed is a potentially wide topic. That topic can be analysed separately – in terms of research method, in terms of the breadth of information sought and in terms of what the responses reveal about both the research and the respondents.

20 Pages 30-33.
21 Page 37.
22 Page 40.
23 Page 42. That report is titled "Māori with disabilities (Part Two)" and is given the Tribunal document reference B23.
24 Pages 57, 58.
25 Pages 60-62.
26 Pages 62, 63.

Chapter two – historical context

34. This chapter outlines the Crown's historical response to the health and wellbeing of Māori with lived experience of disability.

Main points

Introduction

35. Māori autonomy and control is the most fundamental thing for Māori health development.[27]

36. The evidence is unclear regarding whether Māori had access to disability services or not, at least prior to World War II, because evidence of their use of disability services is limited. It is surmised that this is because Māori were dissuaded by the Crown from accessing services.[28]

37. Maori had a different conception of what is a disability from those of Pakeha health professionals, as western views of disability conflicted with the Maori worldviews of health and wellbeing.[29]

From the mid-1840s onwards

38. The report mentions initiatives such as reserving, from 1841, 15 to 20 per cent of Crown land sale proceeds as endowment funds for Māori, including to promote Māori health. Governor Grey set up a public hospital programme in 1847 upon a "European" model as a means to civilise Māori. [30]

39. Tikanga Māori was respected initially in order to provide effective services until hospitals started to become more Pākehā community institutions.[31]

40. Early Māori health development (from 1900) occurred within the context of legislation that supported the Crown's agenda for assimilation of Māori and the dissolution of the Kingitanga.[32]

41. Over the early 1900s, other assimilation strategies were carried out by the Crown. For example, the prohibition of tohunga practice under the Tohunga Suppression Act 1907.[33]

42. From mid-1840s onwards, Crown legislation and policies specifically around disability primarily focused on exclusion. For example, groups of people were excluded from settling in New Zealand as they were not perceived by the Crown as contributing to the 'ideal society', for example legislation prohibited Chinese people from entry, as well as 'cripples, infirm, blind, deaf and dumb'.[34]

43. Support for people with lived experience of disability were expected to be met by families and small amounts of charitable aid.[35]

44. From 1854 'lunatics' were housed in large asylums funded by the Crown. Māori admission rates to the asylums were relatively low compared with that of non-Māori. (Files of Māori in the Auckland Mental Hospital showed that the Crown had been recording the land interests of institutionalised Māori as well as that of their whānau.[36])

---

27 Page 72.
28 Pages 73, 74.
29 Page 75.
30 Page 75.
31 Page 78.
32 Pages 79-81.
33 Page 81.
34 Page 82.
35 Pages 82, 83.
36 Page 84.

45. Specific categories of disability were targeted by eugenicists to prevent reproduction and remove 'undesirables' from society.[37] The report claims that the Crown was heavily influenced by eugenic philosophy even after the Second World War and the exposed horrors of Nazi Germany because of how the Crown went about mass institutionalisation of children and adults in the decades after the war.[38]

46. In the late nineteenth century, residential schools were established for some groups of people with lived experience of disability, particularly those with visual or hearing impairments, considered to be habitable/habilitable. The Crown viewed such groups as having the potential to be trained as fit, working, and productive citizens.[39]

47. As an example, one school was run by the Jubilee Institute for the Blind (later the Blind Foundation). The board of trustees were all male, fully sighted and Pākehā/European. Their authority extended into the personal lives of the sight impaired and blind.[40] The report mentions harvesting blind people from their own communities to place them in institutions in order to secure greater funding streams for the institution.[41]

48. Legislation in the early 20th century made education compulsory for children with visual impairment. For parents of Kāpō Māori, choice was limited, and the Blind Foundation was the only institution that offered services for sight impaired and blind people. The formation of Ngati Kapo Aotearoa was a response to Māori experience of marginalisation and discrimination.[42]

49. In the 1940s, Māori members proposed the integration of te reo Māori me ona tikanga into school lessons, however their proposal was turned down, secondary to the Crown's focus on the assimilation of Kāpō Māori.[43]

From the 1930s onwards

50. The Social Security Act 1938 intended to provide a fully funded health and disability system. This was not achieved due to lobbying of independent medical practitioners (mostly GPs).[44]

51. The return of soldiers from the war with disabilities undermined the eugenics theory of disability and led to the notion of 'rehabilitation'.[45]

52. The polio epidemic lead to the formation of the New Zealand Crippled Children Society which had some engagement with Māori in the beginning. However, Maori were reluctant to seek advice or relinquish their children for hospital treatment. Decades later CCS did seek Māori representation on its national council and committees.[46]

53. Māori health developments from the early 1900s onwards involved numerous voluntary initiatives impacting on the health and wellbeing of Māori. Many of these were initiated and led by Māori women.[47]

37 Pages 87-93.
38 Page 93.
39 Pages 93-94.
40 Pages 94, 95.
41 Page 95.
42 Page 96.
43 Page 96.
44 Pages 97,98.
45 Pages 98-99.
46 Pages 99, 100.
47 Page 100.

54. In the post-war years, the Department of Health and hospital boards were the main disability service providers, along with the Department of Labour which focused on employment placements, and the Department of Social Security which administered financial support.[48]

55. The Disabled Persons Employment Promotion Act 1960 led to employment of people with lived experience of disability in sheltered workshops, but also the exploitation of these people as employers did not need to pay them, and working conditions for disabled employees were not protected. The Act was repealed in 2007.[49]

56. The no fault accident compensation scheme is criticised because it creates inequities between impairments resulting from accidental injury and non-injury-based impairments. In response, the Disabled Persons Community Welfare Act 1975 provided for financial and other assistance for people with lived experience of disability and mandated accessibility standards for buildings.[50] Differential payment between accident and non-accident-based impairments is criticised with ACC payments described as far more generous and holistic.[51]

57. The Hunn report was released in 1961, and while its recommendations aimed to hasten the assumed natural evolutionary path towards the 'integrationist' version of assimilation, it recognised for the first time the number of trends across socioeconomic and health indicators that related to Māori health and wellbeing.[52]

58. More generally, the Health Act 1956 restructured the health system with locally elected hospital boards (29) and district offices for public health and child and maternal health (18).[53] From 1960 an expert committee on Māori health issues was convened by the Board of Health.[54]

59. The 1974 White Paper 'A Health Service for New Zealand' recommended an integrated health service.[55] Medical professionals acted hegemonically to preserve their business model and resist integration, including any collapsing of the distinction between health and disability services.[56] A Special Advisory Committee on Health Services Organisation was convened as an alternative in 1975, resulting in the health reforms of the 1980s.[57]

60. The report sums up engagement: "Over this period there is no documented evidence that the Crown involved Māori with lived experience of disability in: formal consultation; information gathering, defining and identifying issues; deciding on solutions; or implementing health and disability sector policy. This serves to illustrate that Māori with lived experience of disability have been made invisible by Crown engagement with Māori generally, or when it comes to engagement with health and disability sector interest groups."[58]

---

48 Page 101.

49 Page 101.

50 Page 102.

51 Page 102.

52 Pages 103-104.

53 Page 102.

54 Page 102.

55 Pages 105-106.

56 Page 106.

57 Page 106.

58 Page 106.

Deinstitutionalisation

61. Many people with an intellectual disability were housed in institutions. Over time these became very large. Complex purposes and objectives including relieving the community and families of the burden of care for the intellectually disabled.[59] A medical model operated.

62. Māori, who were institutionalised at a very young age, were completely isolated from their culture and birthright.[60] Māori were over-represented among those with lived experience of disability within institutional care.[61]

63. There were many accounts of sexual, physical, emotional and psychological abuse within these institutions.[62]

64. Increasingly, parents and others challenged the idea of leaving children from the age of five in self-contained "mental deficiency colonies". Advocacy groups such as the IHC were established. Later inquiries criticised stridently earlier advice on such segregation.[63]

65. There was considerable criticism about the use of institutions and recommendations to move toward community care. The resulting process known as 'deinstitutionalisation' which continued until the 2000s. However, this process lacked appropriate resource allocation, and there was no support for providing appropriate services for people in the community, or for whanau.[64]

66. There is an ongoing critique about the extent to which re-institutionalisation is occurring in the aftermath of deinstitutionalisation along with results from community care leading to the mere illusion of integration into the community.[65]

Health reforms of the 1980s

67. The Area Health Boards Act 1983 established 14 Area Health Boards responsible for the planning and delivery of government-funded health services but made no provisions for Māori health until the following year when a standing Committee on Māori Health was established.[66]

68. "Rapuora: Health and Māori Women" was released in 1984, discussed holistic health and made a number of recommendations for improvements to Māori health and wellbeing, one of which resulted in Hui Whakaoranga convened under a theme of promoting a positive view of Māori health. Following the hui, the Department of Health identified Māori health as one of its four priorities, and in 1984 created a Māori health project team. However, this was disestablished in 1987, along with the Standing Committee on Māori Health in 1988 (along with all other standing committees).[67]

69. In 1990, the Māori Health Policy Unit was established in the Department of Health. However, three years later all the staff had resigned. A review of the resignations recommended urgent action which lead to a Māori health directorate, Te Kete Hauora, being established led by a new

59 Page 107.

60 Page 108.

61 Pages 108, 109.

62 Page 109.

63 Pages 107-111. See the discussion of the Royal Commission of Inquiry into hospital and related services and its 1973 report titled "Services for the Mentally Handicapped" (at 110) for a critique of the earlier Aitken report's viewpoints and recommendations for community care.

64 Pages 111-113.

65 Pages 111-113.

66 Page 114.

67 Pages 115-117.

Deputy Director-General. This decade has been highlighted as one that involved a shift in emphasis around Crown objectives for Māori health.[68]

Health reforms of the 1990s

70. Heath reforms in the early 1990s led to restructuring and greater numbers of providers within the non-government, non-profit sector. The reforms mandated a purchaser provider split among other structural changes outlined in the report.[69] Growth in providers included Māori owned and governed providers, including disability service providers.[70]

71. The Department of Health and Te Puni Kōkiri published *Whaia te ora mo te iwi* a policy statement in the early 90s which outlined the Crown's 'legislative and regulatory response to Māori health issues' and set out the Crown's objectives for Māori health. These objectives were to underpin the regional health authorities' approach towards the purchasing of health and disability services. The two principal responsibilities to improve health and disability services for Māori were through developing: 1) delivery of services by Māori providers to Māori, and 2) developing culturally appropriate services from 'mainstream' providers.[71]

72. When Māori expressed their unease about the lack of a Treaty clause in the Health and Disability Services Bill, the government gave notice that it did not consider health an Article II issue'.[72]

73. *Te Ara Ahu Whakamua* and *He Matariki: a strategic plan for Māori health* reviewed the prior decade's work on Māori health issues in 1994-1995, including limited progress in by Māori for Māori service provision.[73]

74. The health reforms in the early 1990s introduced considerable changes to disability support services (DSS). The reforms created one source of funding and offered improved access and choice for clients. However, people with lived experience of disability saw this as placing their services within the domain of vote 'health' which categorised them as 'sick'. [74]

75. Research found that although procedures for assessments did appear to have improved, there was not enough funding for DSS to meet the needs of the increased numbers of people who were being assessed as a result of the improved procedures.[75]

76. The coalition government created in 1996 moved away from the quasi-market model approach and towards a collaborative one – meaning another round of health reforms.[76] The continual restructuring of the Ministry of Health has sometimes resulted in Māori providers having to restart

---

68 Page 118.

69 Pages 119-120. See the Health and Disability Services Act 1993, including s 8(e) requiring written notice of the Crown's objectives in relation to the health of Māori people or other particular communities before entering into funding agreements with purchasers of services. Structurally this involved the Public Health Commission and the four Regional Health Authorities.

70 Page 120.

71 Pages 121, 122.

72 Pages 122, 123.

73 Pages 123-126.

74 Page 126.

75 Pages 126, 127.

76 Page 127. The Regional Health Authorities were merged into a Health Funding Authority. Hospital and Health Services replaced Crown Health Enterprises.

their relationship with the Ministry and the report notes that the literature on the reform's impacts on Māori providers of disability services is sparse.[77]

Social and rights-based models of disability

77. Social and rights-based models of disability have resulted in other activities including the Year of the Disabled (1981) and greater advocacy. The Disabled Persons Assembly NZ was established in 1983 and People First in 1987.

78. An amendment by the Crown to the Education Act 1989 also established a policy of inclusion, mandating all primary and secondary schools to admit students with lived experience of disability. Mainstreaming of schooling was opposed by many parents concerned about resourcing.[78]

79. The Human Rights Act 1993 extended the grounds of prohibited discrimination to include disability.[79] Concerns were raised by people with lived experience of disability about the legislation mandating a reasonable accommodation test. It was criticised as an easy escape clause.[80]

80. The summary for this chapter starts: "The Crown's approach to disability issues has been reductionist and ableist, often employing the same strategies of segregation, suppression, and paternalism that characterise the Crown's approach to Māori."[81] The summary concludes: "Overall, the Crown's approach to Māori health and well-being, and to disability since the 1840s has not acknowledged the rights of Māori to be self-determining. Instead, it has restricted the opportunity for Māori with lived experience of disability to develop, establish, and sustain Māori approaches to supporting health and well-being."[82]

Chapter three – the contemporary context

81. This chapter outlines the Crown's contemporary response (from 2000) to the health and wellbeing of people with lived experience of disability in Aotearoa. This covers the health and disability sector's disability framework and international human rights instruments.

The Crown's disability framework in relation to the health and disability sector

82. The Crown's response to the health and wellbeing of people with lived experience of disability is primarily through a complex, 'semi-devolved' health and disability system. This includes the provision of general services and specific disability support services.[83]

83. Services are formalised through a range of mechanisms including legislative, strategic, operational, procurement and delivery of services.[84]

Disability and health sector arrangements

84. The New Zealand Public Health and Disability Act 2000 (the NZPHD Act) is the overarching legislation for the health and disability sector. Functions include: to provide mechanisms for Māori to contribute to decision-making and participate in the delivery of services; to promote inclusion

---

77 Pages 127, 128.

78 Page 130.

79 Page 130. The other prohibited grounds included in this extension were political opinion, employment status, family status and sexual orientation.

80 Page 130.

81 Page 131.

82 Page 132.

83 Pages 132, 133.

84 Page 134, note figure 1's visual depiction of the health and disability system on page 135 (taken from the 2016 *New Zealand Health Strategy: future direction*).

and participation in society and independence of people with disabilities; and to reduce disparities by improving health outcomes for Māori.[85]

85. In practise DHBs are responsible for delivering the majority of quality health and disability services to their population. There is a Ministerial directive for DHBs to reduce disparities by improving health outcomes for Māori.[86]

86. There are no explicit requirements for people with lived experience of disability to be represented on a DHB. The report's author makes a case for an implicit requirement for board appointments of people with lived experience of disability to address diversity objectives a Minister must take account of in making appointments to Crown entities of otherwise qualified persons.[87]

87. Each DHB must convene a Disability Support Advisory Committee.[88] Committees provide advice on the disability support needs of the DHB's resident population and priorities for how to use disability support funding provided to the DHB.

88. DHB's have a significant role in providing disability support services. Despite broader policy objectives for devolution of purchasing responsibility to DHBs, central purchasing of services by the Ministry of Health has remained in place largely for persons under age 65 with DHB provision of services largely addressed to people aged over 65 (or those aged 50 and over with conditions closer in interest to older people). The Ministry acknowledges that many support services are not appropriately tailored to individual needs.[89]

89. The authors question whether the fragmentation (by age groups) within an already fragmented system of funding, with no follow-through on full devolution to DHBs, nor evaluation of the impacts of such policy on Māori with lived experience of disability, is likely to have contributed to the inequities demonstrated for Māori with lived experience of disability.[90]

90. The NZPHD Act provides for four other health agencies: PHARMAC, New Zealand Blood Service, Health Promotion Agency and the Health Quality & Safety Commission. The Commission has a statutory objective to lead and coordinate work across the health and disability sector for the purpose of improving the quality and safety of disability support services.[91]

91. The report cites the Crown's briefing to the incoming Minister as identifying three other "agencies" established under their own legislation that are relevant to the Crown's disability framework pertaining to the health and disability system. These Crown entities are: the Accident Compensation Corporation (ACC) funding injury services resulting from accidents, the Health Research Council of New Zealand, and the Health and Disability Commissioner investigating complaints to ensure health and disability service consumer rights are upheld.[92]

---

85 Page 136.

86 Page 137.

87 Page 137. See the New Zealand Public Health and Disability 2000 s 29 and read against the Crown Entities Act 2004's provisions also applicable to DHB appointments. This is a topic for legal submissions in due course.

88 Page 137.

89 Page 138.

90 Pages 139-143. Given differences in life expectancy and other equity implications for Māori, this proposition needs to be examined.

91 Page 144.

92 Page 144. Note that legal submissions will address the status of these Crown entities and the independent functions they perform as well as the areas where the Crown has some responsibility for or influence over their operations.

92. Other health legislation relevant to Māori with lived experience of disability include: the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, and the Mental Health (Compulsory Assessment and Treatment) Act 1992, and the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003.[93]

Guidance to, and expectations of the health and disability sector

93. The Minister of Health retains a stewardship role in the health and disability sector and, through the Ministry, maintains an overview of the whole system including the regulatory environment, as well as setting policy direction and strategy.[94]

94. The second New Zealand Health Strategy (NZHS) was released in 2016. This version has less of an explicit focus on Māori health and disability outcomes than the earlier strategy released in 2000.[95]

95. The NZPHD Act also provides for a Minister of the Crown with responsibility for disability issues to determine a strategy for disability support services, the first of which was launched in 2001 and was based on the social model of disability. There is an Associate Minister of Health with responsibility for disability issues.

96. The disability strategy was updated in 2016 (NZDS). The NZDS identifies that it will be guided by 'the principles of te Tiriti o Waitangi' (adopting principles of participation, partnership and protection).[96]

97. The strategy is accompanied by an action plan agreed to by cabinet which sets priorities across all government agencies. The author stated that the plan was due to be updated in 2017 but it has not been.[97] The report was presumably written before the replacement action plan was launched on 14 November 2019.[98]

98. Implementation of the plan is supported by the Office for Disability Issues (ODI), which is a small policy team housed within MSD. ODI are also responsible for coordinating and reporting on Aotearoa's implementation of the UN Convention on the Rights of Persons with Disabilities.[99]

99. Whāia Te Ao Mārama – the Māori Disability Action Plan 2018–2022 is an action plan aligning with He Korowai Oranga and is overseen and monitored by Te Ao Mārama, the Māori disability advisory group.[100]

---

93 Page 145. Pointing to the purposes of the Mental Health (CAT) Act, the author states "The fact that compulsory assessment and treatment is referred to [by the Ministry of Health] as an entry point to services, however, does highlight certain limitations regarding the implementation of preventive care." (Page 146.) This might risk downplaying other entry points for services, or the significance of compulsion deployed under this legislation.

94 Page 146.

95 Page 146.

96 Pages 147, 148.

97 Page 148. The author states at page 148 that "only seven out of the 28 actions were actually completed" (presumably at the time of writing) but this appears to overlook the reporting system on progress for each action where, in addition to noting completed actions, others were described as on track for completion, facing minor risks to achieving completion or unlikely to be completed without significant intervention.

98 The 2019-2023 Action plan was launched by the Minister for Disability Issues. https://www.odi.govt.nz/disability-action-plan-2/.

99 Page 149.

100 Pages 149, 150. The report states at page 149 that progress in achieving actions under *Whāia te Ao Mārama* is behind schedule and questions whether this "could be because *Whāia te Ao Mārama* is not one of the key priority areas in the overall work programme for the Disability Directorate". The basis for asserting that this plan is not a key priority area is not referenced, nor is the basis for assessing that it is not on track. A Crown response on these issues can be provided.

100. Although not required by legislation, the Māori health strategy, *He Korowai Oranga* (2014) is intended to guide the Government and the health and disability sector to achieve its aims for Māori. It does not have an associated action plan, or assigned budget, but the Ministry has indicated that an action plan is now under development.[101]

101. There are other specific policy documents that guide health and disability service that have relevance to Māori with lived experience of disability. These include annual expectations for health Crown entities and annual planning guidance.[102]

Current Ministry of Health structure

102. The Ministry's organisational structure (at October 2018) re-introduced both a disability directorate and a Māori health directorate. There is no reference to Māori with lived experience of disability in any part of the document on organisational structure and the renewed focus on Māori is for health services rather than disability services. Te Ao Mārama were not consulted on the restructure.[103]

Other Crown organisations responsible for health and disability services

103. Other Crown organisations provide or are responsible for delivery of health and disability support services, despite this not being their primary function.

104. The Department of Corrections provides some health services and disability support services to people in prisons. Other services are provided by DHBs, funded by the Ministry of Health and covered by a memorandum of understanding the Department has with the Ministry of Health. The Department's website states that people in prison who are eligible for disability support services receive the same level of support as they would in the wider community, funded through DHBs.[104]

105. DHBs provide regional services for persons with either mental health issues or learning/intellectual disability who are subject to compulsory treatment under the criminal justice system[105]

106. Before 2009, health and disability services for youth in Child Youth and Family residences[106] were provided by the Ministry for Social Development. Since 2009 this is provided through DHBs.[107] Funding agreements reached through memoranda of understanding were inherited by Oranga Tamariki the Ministry for Children.

Procurement and provision of disability support services

107. "Disability support services (DSS) are stated to be available to people who have a physical, learning/intellectual or sensory disability (or a combination of these), that is likely to continue for at least six months and,'...limits their ability to function independently, to the extent that ongoing support is required'. As previously discussed, the MoH generally does not fund DSS for personal health conditions, mental health conditions, or conditions more commonly associated with ageing.

---

101 See https://www.health.govt.nz/our-work/populations/maori-health/maori-health-action-plan for the latest news on the proposed action plan (last updated 18 October 2019; last accessed 8 May 2020).

102 Pages 150, 151.

103 Pages 152, 153. Were Maori with lived experience of disability considered expressly in the restructure? Were these people an explicit part of the rationale for the new organisational structure? (See p 152.)

104 Page 154. This introduces confusion as to whether Ministry-funded disability support service are provided to people in prisons given the limited scope of disability support services that DHBs have had devolved to them.

105 Page 154.

106 Care and protection and youth justice residences.

107 Pages 154, 155.

Nor does the MoH fund services for disability caused by accident or injury as these are funded by ACC."[108]

108. To access DSS, the most common approach is for a person to have a needs assessment through a Ministry-contracted Needs Assessment and Service Coordination Service (NASC). A NASC can also review eligibility for funding.[109]

109. The report states there is inconsistency between the legislation's expectations for services and eligibility and purchasing guidelines for DSS procurement. The purchasing is prescriptive.[110]

110. There are only 33 Māori providers (3.4 per cent) out of 980 providers (96.6 per cent). For the 2017/18 year, Māori providers received only 3.9 per cent out of the total DSS expenditure.[111]

111. There appear to be no Māori disability providers in the following six DHB areas: Taranaki, Mid-Central, Hutt Valley, Wairarapa, Nelson-Marlborough, and South Canterbury.[112]

112. Lack of details from the Ministry and lack of DHB data and monitoring makes it hard to track needs across DHB regions and whether service provision is appropriate.[113]

113. Almost 25 years ago, a report commissioned by the National Advisory Committee on Core Health and Disability Support Services advised that Maori will continue to use mainstream disability support services so these must be culturally appropriate. However, this alone will be insufficient to meet Māori needs, and Maori specific providers will be needed.[114] There are few options available to Māori to access disability support services provided by Māori.[115]

114. Identified barriers to access disability services include negative or racist attitudes from providers and difference in care levels provided to Māori compared to non-Māori.[116] Research reports illustrate that the position is unsatisfactory.

115. Māori consumers of disability support services who were surveyed in a report commissioned by the Ministry gave dissatisfied or barely satisfied ratings to mainstream providers and most would prefer a Māori provider.[117]

116. Following legal action in 2012, the Ministry of Health introduced funded family care in 2013. In 2018 the government announced it would make some changes to the policy, including repealing

---

108 Page 155.

109 Pages 155, 156.

110 Pages 156-158. Readers will recall the statute's injunction to achieve its objectives to the extent these are reasonably achievable within the funding provided (s (3)2, acting as a qualification on s 3(1)). The report states at p 157 that the proportion of Māori utilising equipment and modification services has increased over the period between 2014/15 to 2017/18 (8.9 to 10.2 per cent) but the proportion of expenditure for Māori has actually decreased over the period (15.0 to 13.9 per cent). (See table 7a at p 160 of the report.) When calculated for expenditure for each person, Maori in 2014/15 received $1785, and non-Maori $994. In 2017/18 Maori received $1836 a person, and non-Maori $1285. In both years Maori received more funding on the basis of each person served. The gap in funding has, however, narrowed from $791 in 2014/15 to $551 in 2017/18.

111 Pages 161-162. See table 7b identifying Māori-owned and Māori-governed disability providers by district and by services provided.

112 Page 158.

113 Page 159.

114 Pages 164-166.

115 Page 165.

116 Pages 166-170.

117 Page 166 citing *Nikora et al*.

Part 4A of the New Zealand Public Health and Disability Act 2000 because it was inconsistent with human rights legislation.[118]

117. Replacement family policies were not settled when this report was finalised (2018). Funding of levels of care are assessed by a NASC. The extent of engagement with Māori over replacement policies is questioned in the report.[119]

118. The Government is trialling a disability support system transformation project called Mana Whaikaha in the MidCentral DHB area.[120] It is based on Enabling Good Lives principles.

International human rights instruments and frameworks

119. New Zealand ratified the UN Convention on the Rights of Persons with Disabilities (UNCRPD) in 2008, the same year it came into force.[121]

120. The UNCRPD signalled a shift from seeing disability as a charity-oriented, medical approach to one based on human rights.

121. Aotearoa was actively involved in the negotiation and drafting of the UNCRPD and the Stage involved several people with lived experience of disability.[122] The report raises doubts about whether Māori with lived experience of disability participated in the development of the Convention.[123]

122. The government established a framework in 2010 to monitor implementation of the Convention, including the establishment of an independent monitoring body.[124] Implementation of UNCRPD is overseen by the ODI in collaboration with the Disabled People's Organisations (DPO) Coalition.[125]

123. New Zealand reports periodically under the Convention about how well the rights articulated within the UNCRPD are being implemented by the government.[126] In 2014 the examining Committee made 34 recommendations to the government to improve implementation of the UNCRPD. This included recommendations regarding issues for Māori.[127]

124. In 2014 a Special Rapporteur on the rights of persons with disabilities was established as part of the special procedures mandate of the UN Human Rights Council.[128]

118 Pages 170, 171. The legislative and then detailed policy changes are expected to occur in 2020. The Ministry's website (last accessed 8 May 2020) warns there may be some delay due to the impact of COVID-19 responses.

119 Page 171.

120 Page 172. A report on the baseline study for this project was published on the mana whaikaha website in 2019 (last accessed 8 May 2020): https://manawhaikaha.co.nz/about-us/evaluation/baseline-study/

121 This section of the report starts with a broader review of international human rights instruments since the creation of the United Nations. See pp 173-174.

122 Page 175.

123 Page 175.

124 Pages 178-190.

125 Page 175. "The DPO Coalition currently comprises seven organisations made up of and/or primarily governed by, people with lived experience of disability. These are: Kāpō Māori Aotearoa New Zealand Inc.; Association of Blind Citizens of New Zealand Inc.; Balance Aotearoa; Deaf Aotearoa New Zealand Inc.; Disabled Persons Assembly New Zealand Inc.; Muscular Dystrophy Association of New Zealand Inc.; and People First New Zealand Inc."

126 Pages 175, 176.

127 Pages 177-178. The recommendations are set out on these pages.

128 Page 178.

125. In 2016 Aotearoa acceded to the optional protocol to the UNCRPD allowing further levels of investigation by the examining Committee of individual complaints of breach of the Convention rights and inquiries into suspected human rights violations.[129]

126. The UN Convention on the Rights of the Child (UNCROC) was ratified in 1993. Implementation of UNCROC is overseen by MSD. Articles 2, 23, 24, 30 of UNCROC broadly relate to the health and wellbeing of Māori children with disability.[130]

127. A 2016 UN committee report recommended steps to combat marginalisation of disabled Māori children.[131]

128. The UN Declaration on the Rights of Indigenous Peoples (UNDRIP) was adopted in 2010. Crown implementation of the UNDRIP is overseen by TPK.[132] A monitoring mechanism for UNDRIP was created by Māori and is independent of the government.[133]

129. Experts, considering the implementation of conventions across many countries, have examined the crossover between the UNDRIP with its collective focus for indigenous peoples' and the greater focus on individual rights in the UNCRPD.[134] Indigenous peoples with lived experience of disability are not aware of their human rights in cases among many other challenges identified.[135]

130. Experts have identified community-based approaches as the most suitable framework for the overall inclusion of indigenous peoples with lived experience of disability, and for the provision of support services.[136]

131. The main points made in chapter 3 are summarised from pages 200-201.

Chapter 4 – data review Part 1

132. This chapter presents Part 1 of a data review. The review is of information provided under the Official Information Act in response to the author's requests. A selection of Crown organisations has been made for this data review.

Crown-held information for Māori with lived experience of disability and databases

133. Data quality issues undermine disability planning. Data collection issues are identified.[137]

134. Only a few data sources appear to be used to inform policy advice or monitoring of the experience of the quality of services received and these have a narrow focus or are service-centric, for example only focusing on those who meet eligibility criteria for DSS in the case of the Crown's Socrates disability national database.[138] Disability cannot be identified in the majority of national

129 Page 176.

130 Page 191.

131 Page 192.

132 Pages 192-194.

133 Pages 195, 196.

134 Pages 197-198.

135 Page 199.

136 Page 199.

137 Page 204. The author also mentions weaknesses in the 2018 New Zealand census.

138 Pages 205-206. The author further mentions a failure to complete an action (9E) from the 2014-18 Disability Action Plan concerning a work programme to improve data coverage and quality for Māori with lived experience of disability. Information is needed about whether this work was picked up elsewhere or was overtaken by other work. Further, whether a recognition has emerged on the need to collect indicator statistics on progress against objectives/outcomes in an outcomes framework (see the Disability Strategy Outcomes Framework).

health surveys. However, the Washington Group Short Set was added to the *2018/19 New Zealand Health Survey*.[139]

135. Table 9 – Outline of databases used by the Ministry of Health that hold data for Māori with lived experience of disability.[140]

136. Table 10 – Ministry of Health's main data used for monitoring performance of the health and disability system in relation to Māori with lived experience of disability.[141]

137. Table 11 – The Ministry of Health's main disability data used for Māori for health and disability policy purposes.[142]

Health and disability research

138. The Health Research Council's total funding for health research is presented broken down by Māori and non-Māori. The author says this has proportionately decreased for Māori, and has increased for non-Māori over the five-year period from 2014 to 2018.[143] However, tables 12(a) and 12 (b) do not present so stark a picture and shows the proportionate share of total funding across 2014-2018 period at 12.4:87.6 percent.[144] The report does not address the content of the research undertaken and the intended subjects and beneficiaries of that research.

139. The Health Research Council does not ring-fence funding for Māori health research about disability.[145]

Seclusion and restraint of Māori with lived experience of disability

140. In 2017 seclusion and restraint were identified by the monitoring mechanism as issues for the Committee on the Rights of Persons with Disabilities to raise ahead of New Zealand's next periodic report. The issue has been the subject of recent independent reports.[146]

141. Māori are more likely to experience seclusion than any other ethnic groups in Aotearoa/New Zealand.[147] The settings it occurs in are set in the context of compulsory treatment or compulsory care. See s 71 of the Mental Health (Compulsory Assessment and Treatment) Act 1993 and s 60 of the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (ID(CC&R)).[148]

142. There is a significant cross-over issue to this inquiry's mental health phase. The author notes that the Ministry of Health has suggested that people secluded under the Mental Health Act are considered as having a disability, considering the definition of disability in the UNCRPD.[149]

143. The Ministry of Health states that seclusion should be an uncommon event. However, a report on seclusion and restraint suggests Ministry and DHB high-level commitment does not always appear evident on the ground. The same report also criticises the lack of appropriate monitoring

---

139 Page 206.

140 Pages 208-211: Socrates, PRIMHD, CCPS, CMS, NMDS, NNPAC and NZ Health Survey.

141 Page 212: DSS, EMS, learning/intellectual disability, system transformation and mental health.

142 Page 213: Socrates and PRIMHD.

143 Page 215.

144 Page 215. The Health Research Council operates under the Health Research Council Act 1990. See tables 12(a) and 12(b) on pp 216-217.

145 Page 215.

146 Page 218.

147 Pages 218-220.

148 Page 221.

149 Pages 225-226.

regarding the use of restraint in health and disability services.[150] "Whether or not the reduction in seclusion use over time has occurred for all Māori who are admitted to inpatient services in Aotearoa/New Zealand remains unclear."[151]

144. There is significant variation in seclusion rates across DHBs.[152]

Trends in seclusion over time in health and disability services

145. Seclusion events decreased from 2008-2017.[153]

146. For MH(CAT) Act authorised seclusion, in 2009 seclusion rates for Māori was 64 per 100,000 population compared with 19 per 100,000 population for non-Māori. In 2017, the rate for Māori was 57 per 100,000 population compared with 13 per 100,000 population for non-Māori.[154]

147. For adult in-patient services (adult, forensic and youth) seclusion events, in 2009, when the seclusion reduction policy was introduced, the rate for Māori was 89 per 100,000 population compared with 25 per 100,000 population for non-Māori. In 2017, the rate for Māori was 84 per 100,000 population compared with 18 per 100,000 population for non-Māori.[155]

148. For forensic inpatient services seclusion events, in 2009 the rate for Māori was 21 per 100,000 population compared with 3 per 100,000 population for non-Māori. In 2017, the rate for Māori was 13 per 100,000 population compared with 1 per 100,000 population for non-Māori.[156]

149. The conclusion is (page 234): "Overall, the figures and tables indicate that the significant inequities in rates of secluded Māori compared with non-Māori have increased over the 10-year period examined and this occurred across all of the inpatient services examined. This occurred following the time that the seclusion reduction policy was implemented (from 2009 onwards). However, the inequity in the rates of seclusion events for total Māori compared with non-Māori have decreased over the 10-year period. This decrease has been driven by a decrease in the rates of seclusion events for Māori compared with non-Māori in adult inpatient services over the 10-year period, but this trend has not occurred elsewhere in the other inpatient services examined."

150. Five DHBs provide specialist inpatient forensic services.[157] The Ministry of Health reports on seclusion data for care recipients with a legal status under Intellectual Disability (Compulsory Care and Rehabilitation) Act separately to people secluded under the Mental Health Compulsory Assessment and Treatment) Act. Data is only available for 2017 for seclusion under the Intellectual Disability (Compulsory Care and Rehabilitation) Act.[158]

151. Figures 5 and 6 show that both the number and proportion of Māori subject to the ID(CC&R) Act have increased over time, whilst the proportion of non-Māori has decreased over the 10-year period.[159]

150 Page 222.

151 Page 224.

152 Page 223.

153 Pages 232, 233.

154 Page 228 figure 2. The author notes the rate ratios have not been age standardised for these data.

155 Page 229 figure 3.

156 Page 230 figure 4.

157 This includes data on persons admitted to Regional Intellectual Disability Secure Services (RIDSS). See pp 234-235.

158 Pages 235, 236.

159 Pages 236, 237.

152. Hospital level secure bed provision occurs through a High and Complex Framework (HCF). The HCF deals with individuals with an intellectual disability who present significant risk to themselves and/or others and have been engaged with the criminal justice system. It supports people under orders from the ID(CC&R) Act. The numbers of Māori admitted to hospital level secure beds over the 10-year period have ranged from two to 10, compared with four to 19 for non-Māori.[160]

153. Capacity limitations for this level of care became an issue for the first time in 2018. At the time of writing all regions were operating at capacity.[161]

154. Māori were 1.7 times more likely to be secluded multiple times than non-Māori.[162] In 2017, the proportion of Māori among all persons secluded under the ID(CC&R) Act was 32 percent.[163]

The Crown's plan to address seclusion use in health and disability services

155. Te Pou o te Whakaaro Nui (Te Pou) is a national centre of workforce development for the mental health, addiction and disability sectors in Aotearoa/New Zealand and is funded by the Ministry of Health in relation to seclusion reduction.[164]

156. Te Pou along with the Health Quality & Safety Commission launched a national plan in 2018 to eliminate seclusion by 2020, but this is stated an aspirational goal rather than a target.[165]

157. The author points to a disconnect she perceives between HQSC narrative around aspiring to eliminate seclusion by 2020 and that of the Ministry, including when the Crown presents on these issues to international audiences in reporting on issues under the UNCRPD.[166]

Monitoring of health and wellbeing, and health and disability support services in prisons

158. There are significant inequities in the proportion of Māori imprisoned compared with non-Māori.[167]

159. Data regarding prisoners with disability and mental health issues is not collected on an aggregate basis and is not available. That is except for a small amount of data regarding visual and hearing impairment.[168] Information about the individual health and disability needs of prisoners is collected on reception into prison.[169]

ARUs

160. At-Risk Units (ARUs) are to provide a safe environment for those in prisons who are at-risk of self-harm. The extent of use of ARUs is subject to critique. Māori men have similar figures to that of non-Māori men. Māori women have been trending downwards against non-Maori women.[170]

160 Page 238. See Figure 7 on p 240.

161 Pages 239, 240.

162 Page 242. See Figure 9 on p 242. Compare to the proportions of Māori and non-Māori secluded in Figure 8 on p 241.

163 Page 240 and see Figure 8 on p 241.

164 Page 244.

165 Pages 245, 247.

166 Pages 246, 247.

167 Pages 250-254. Data to 2017.

168 Pages 255-259.

169 Pages 248,255.

170 Pages 259-263.

161. For 2017, the proportion of periods started in an ARU for Māori men was 49 per cent compared with 51 per cent for non-Māori men. For Māori women it was 49.5 per cent compared with 50.5 per cent for non-Māori women.

162. Corrections does not hold information about the number of Māori with lived experience of disability that are placed within the ARUs in prisons.[171]

Directed segregation

163. Prisoner's may also be segregated for purposes such as security, good order and safety under the Corrections Act 2004.[172]

164. In 2017 Māori (64 percent) were 1.7 times more likely to be segregated than non-Māori (36 percent) in the men's prisons. Māori (65.9 percent) were 1.9 times more likely to be segregated than non-Māori (34.1 per cent) in the women's prisons.[173]

165. Corrections does not hold information about the numbers of Māori with lived experience of disability that are placed in directed segregation in prisons.

Mechanical restraints

166. Mechanical restraints are not permitted in healthcare services but are permitted under the Corrections Act 2004. Corrections collects data about total use of retraints but this is not broken down by ethnicity or disability. Therefore, Corrections cannot collate data around ethnicity and disability in the use of restraints.[174]

Conclusions

167. Because Corrections do not collect aggregate data on the use of ARU's, directed segregation or mechanical restraints on Maori with disabilities in prison, the author states that the Crown does not have appropriate mechanisms in place for monitoring its own use of segregation/restraint on Māori with lived experience of disability in prison.[175]

Monitoring of health and disability services in the Ministry for Children's care and protection and youth justice residences

168. There are significant inequities for Māori compared with non-Māori, in the numbers of children and young people in Oranga Tamariki – the Ministry for Children's care and protection and youth justice residences per year for the 10-year period from 2008 to 2017. The proportion of Māori has increased from 59.6 per cent to 81.2 per cent, and non-Maori has decreased from 40.4 per cent to 18.8 per cent.[176]

169. Aggregate information on the numbers of Māori children and young people with lived experience of disability in care and protection and youth justice residences was not provided to the researcher as the Ministry refused to collate the data from individual files. This is the case also for health and disability support services and 'secure care' placement.[177]

171 Page 263.

172 Page 264.

173 Pages 265–267.

174 Pages 268, 269.

175 Page 263, 268, 270.

176 Pages 272-275.

177 Pages 276-278 and 282.

170. The author's conclusion is that the Crown does not have appropriate mechanisms in place for monitoring: [178]

(a) access to health and disability support services to ensure that health and disability support needs are being met for those in the care of Oranga Tamariki; and,

(b) its own use of 'secure care' placements on Māori children and young people, and Māori children and young people with lived experience of disability within its care and protection and youth justice residences.

Chapter 5 – Data review part 2

171. This chapter presents Part 2 of the review of the information that was provided by a selection of Crown organisations in response to researcher requests made under the Official Information Act. The chapter attempts to provide a thematic analysis of a selection of that information against Tiriti o Waitangi/Treaty of Waitangi principles.[179]

The Ministry of Health[180]

Partnership

172. It is not clear whom the Ministry of Health considers to be its partners when it comes to Māori health and disability issues. While the Ministry includes Māori with lived experience of disability in decision making through Te Ao Mārama, a review of meeting minutes over 18 months shows limited engagement.[181]

Participation

173. Māori participation in committees appointed by the Minister of Health is common, but not universal, and participation in committees by Māori with lived experience of disability is unknown. The author also states that Maori are not involved in relevant projects, and that the Ministry's information responses show an instance of engaging with other government agencies as a proxy for 'engaging with Māori'.

174. The Ministry does not set explicit standards for DHBs when it comes to involving Māori with lived experience of disability in decision making.[182] A focus at present is Māori leadership roles.[183]

Options

175. There are only a small number of Māori DSS providers (33 identified) operating in a large disability support service sector (total of 980 providers).[184]

Active protection

176. Little information was provided about training and induction for working with Māori and Māori with disabilities.[185]

178 Pages 278-281.

179 The report explains, in chapter one, the selection of Treaty principles used in this analysis in describing its methodology.

180 See summary table pages 294-299.

181 Page 288.

182 Pages 289-290.

183 Pages 290-291.

184 Page 291.

185 Page 292.

177. There is no effort demonstrated on ensuring spending is targeted toward Māori with lived experience of disability.[186]

Equity

178. The Ministry can provide examples of how its monitoring can identify inequities. However, there is no evidence that the Ministry acts to address the health need of Māori with lived experience of disability when such inequities are identified.[187] Equity settings are reinforced by the Ministry in guidance provided to DHBs for planning purposes but there is nothing specific about Māori with lived experience of disability in this general guidance.[188]

179. Quality data for Māori with lived experience of disability is very limited, and this impacts on the Ministry's ability to monitor its contracted services to ensure that they are achieving equity for Māori with lived experience of disability.[189]

Table 16 – summarising Treaty principles thematic analysis of the Ministry's work

180. Table 16 (pages 294-299) sets out, in summary form, a number of criticisms about the Ministry's approach to disability when seen against a thematic Treaty principles analysis.

District Health Boards

Partnership

181. District Health Boards make high level statements about the 'Treaty partnership', but this does not translate into policies and practices. there is little information to suggest that Māori with lived experience of disability are involved in organisational decision making in a meaningful way.[190]

182. See Table 17 summarising criticisms about how DHBs address partnership issues (pages 301-303). DHBs rely on relationship boards and while these can extend to connections those board members have to people with lived experience of disability this does not amount to Māori with lived experience of disability being in partnering roles.

Participation

183. DHBs appear passive about participation of Māori with lived experience of disability.[191]

184. The author concludes there are no Māori board members with lived experience of disability on DHB boards throughout Aotearoa/New Zealand. Three DHBs indicated they have board members with lived experience of disability but in all cases, these board members are non-Māori. There is a notable lack of information on board members, and discrepancies between what information the Ministry of Health holds, and what DHBs released under the Official Information Act on board membership.[192]

185. Beyond ensuring physical access to meetings and accessible parking, there is little evidence of DHBs ensuring participation needs are met.[193]

---

186 Page 292.

187 Page 293.

188 Page 292.

189 Page 293.

190 Pages 299, 303.

191 Page 304.

192 Pages 303. The report also states just over half of DHBs hold information on disability and its members, meaning the conclusion about board members with lived experience of disability needs to read alongside this data collection issue.

193 Page 304, summary tables 305-309.

186. Participation of Māori with lived experience of disability in alliance leadership teams, consumer groups or clinical governance is rare, or non-existent.[194]

187. Māori staff numbers were low and Māori staff with lived experience of disability were almost non-existent. No specific steps were recorded about increasing the workforce.[195]

188. No DHB held information on how much it spent on services provided by Māori with lived experience of disability, and there was no requirement for contracted providers to support workforce development of Māori with lived experience of disability.[196]

189. No definition of co-design or inconsistent definitions of co-design for projects said to be subject to co-design.[197]

190. See Table 18 summarising criticisms about how DHBs address participation issues (pages 304-309).

Options

191. District Health Boards were not able to show how much funding was spent on services by Māori-governed or owned health and/or disability support providers, for Māori with lived experience of disability. Where funding details were provided by DHBs, it demonstrated that funding for Māori health providers was very low relative to total DHB funding.[198]

192. See Table 19 summarising criticisms about how DHBs address options issues (pages 310-311).

Action protection

193. District Health Boards do not have accountability mechanisms to ensure services are responsive and effective for Māori with lived experience with disability. DHBs did not, or were unable to, provide information about complaints made by Māori with lived experience of disability.[199]

194. DHB health promotion programmes do not have a focus usually on Māori with lived experience of disability.[200]

195. DHBs do not interrogate their funding to analyse whether Māori with lived experience of disability receive appropriate health and disability care funding. Where funding was disaggregated by ethnicity and disability over time, Māori with lived experience of disability were shown to be least likely to receive funding increases.[201]

196. Most DHBs reported providing some form of Māori responsiveness training and many provided disability responsiveness training. However, DHBs did not offer training that covered both aspects of responsiveness.[202]

197. See Table 20 summarising criticisms about how DHBs address active protection issues (pages 314-316).

194 Page 304.

195 Page 304.

196 Page 304.

197 Page 304.

198 Pages 309-311.

199 Page 312.

200 Page 312.

201 Page 312.

202 Page 313, summary tables 314-316.

Equity

198. District Health Boards repeated high-level equity statements throughout their key strategy documents. However, the quality and impact of these statements was variable and rarely included reference to Māori with disabilities.

199. DHBs do not collect information on Māori with lived experience of disability, so there was no information on the performance monitoring of services for Māori with lived experience of disability.[203]

200. See Table 21 summarising criticisms about how DHBs address equity issues (pages 318-321).

Crown health agencies

Partnership

201. For organisational decision making by Crown health agencies, there were no formal policies for involving Māori with lived experience of disability. Some, but not all, agencies have Māori board members.[204]

202. See Table 22 (pages 322-323).

Participation

203. It is rare for Māori with lived experience of disability to be included in Māori advisory and other groups. Outside of these advisory groups there was limited information provided on how Māori with lived experience of disability were consulted on regarding the work of organisations.[205]

204. See Table 23 (pages 325-326).

Active protection

205. There was no information provided on whether services were responsive to the needs of Māori with lived experience of disability (and only two agencies were asked about responsiveness). On workforce responsiveness, most agencies offer some kind of Māori responsiveness or cultural competency or safety training. They do not usually offer disability responsiveness training.[206]

206. See Table 24 (pages 328-330).

Equity

207. Most agencies do have high-level equity statements or objectives for Māori. However, these statements do not make reference to disability issues or Māori with lived experience of disability, with the exception of ACC which focuses on health equity for Māori as well as injury prevention.[207]

208. Agencies were unable to provide a breakdown of their spending based on population by ethnicity and/or disability. Agencies do not include disability issues in their health quality data.[208]

203 Pages 317-321.

204 Pages 321-323.

205 Pages 324-326.

206 Pages 327-330.

207 Page 330.

208 Page 330, summary tables 331, 332.

209. The HQSC reports on health inequities, but its response was that it is unable to lead system change to support equity. Thus, the impacts of lack of data and analysis are compounded by the Crown not acting on information that it does have.[209]

210. See Table 25 (pages 331-332).

Office for Disability Issues (ODI)[210]

Partnership

211. ODI does not address partnership directly but does indicate it follows the 'three P's' (which does include partnership) outlined in the New Zealand Disability Strategy.[211]

Participation

212. ODI works with the Disabled People's Organisations (DPO) in developing strategy and policy work. Outside of the DPO (which includes Kāpō Māori Aotearoa), there is little evidence provided of ODI engaging with, and involving Māori with lived experience of disability, other than through occasional consultation.[212]

Options

213. If specialist Māori advice was required, then the ODI would seek advice from, or refer the agency to, Kāpō Māori Aotearoa specifically.

Active protection

214. The ODI does not offer training to individuals on Māori responsiveness, though some staff have Treaty training.[213]

Table 26 – ODI responsiveness analysed thematically by Treaty principles

215. See Table 26 (page 334).

Representation of Māori with lived experience of disability on health and disability sector boards and committees

216. Table 27 presents a breakdown of Māori and non-Māori members on ministerial committees. The Ministry of Health does not have information on whether members on ministerial committees have lived experience of disability.[214]

217. Table 28 presents a breakdown of board membership of District Health Boards by ethnicity and disability. Not all DHBs hold information on the ethnicity of board members, and just over half hold information on whether board members have lived experience of disability.[215]

218. Table 29 presents a breakdown of membership of DHB Disability Support Advisory Committees by ethnicity and disability. When it comes to decisions relevant to Māori with lived experience of disability, DHBs largely rely on the Māori representation on these committees.[216]

---

209 Pages 330-331.

210 Summary table page 334.

211 Page 333.

212 Page 333.

213 Page 333.

214 Pages 336-340.

215 Pages 341-342.

216 Pages 343, 344.

219. Table 30 presents the numbers of Māori and non-Māori members of the Health Quality & Safety Commission (HQSC) Board and other advisory groups/committees. The HQSC said that 'membership of our advisory bodies is not determined by the disability status of applicants. We do not collect data specifically related to Māori disability'.[217]

Representation of Māori with lived experience of disability in the health and disability sector workforce

220. The number of Māori with lived experience of disability employed in one of the 32 public service departments is unknown.[218]

221. It is estimated that the rate of disability in the public service (at 16 percent), is slightly less than the rate of disability in the workforce overall (at 19 percent).[219]

222. Māori make up 16 percent of the public service workforce, but Māori are underrepresented in the top tiers of the public service.[220]

223. Health sector agencies, including the Ministry of Health, were not able to provide information on consultants and contractors broken down either by ethnicity, or by disability status.[221]

224. A number of health sector agencies provide ethnicity and sometimes disability information about their employees in annual reports. Overall agencies employ a low percentage of Māori within their organisations. ACC is the highest, at 12 percent. For the remainder, between four percent and seven percent of staff are Māori, with similar rates of staff with lived experience of disability.[222]

Summary

225. Māori with lived experience of disability are made invisible by Crown organisations. Where those organisations demonstrate responsiveness to Māori this does not include Māori with lived experience of disability. Where organisations demonstrate responsiveness to people with lived experience of disability this "does not usually include" Māori. Presumably this is meant to state the author's view that responsiveness to Māori with lived experience of disability cannot be achieved by being responsive to both Māori and to the class of persons with lived experience of disability. The result, the author argues, is that this leads to inaction on the part of the Crown about the health and well-being interests of Māori with lived experience of disability.[223]

Conclusions and answer to commission questions

What key historical developments have contributed to the current system of government disability services for Māori and to Māori experiences and attitudes to disability services?[224]

226. The key historical developments and contemporaneous Western models of disability described in this report denote Crown actions and inactions contributing to the poor treatment of Māori with lived experience of disability, and the resultant inequitable health outcomes.

217 Pages 345, 346.

218 Page 346.

219 Page 346.

220 Page 346.

221 Page 346.

222 Pages 347, 348.

223 Page 349.

224 Page 354.

To what extent have Māori had opportunities to contribute to relevant policy and legislative developments?[225]

227. Despite many contemporary reforms, the needs of Māori with lived experience of disability are made invisible, illustrating one aspect of the disconnect between policy and practice that disproportionately impacts on Māori with lived experience of disability.[226]

228. Māori with lived experience of disability are not actively prevented from participating in policy and legislative developments, but neither is the opportunity to participate guaranteed, or actively sought by the Crown. Nor is there evidence that reasonable accommodations and supports are put in place by Crown organisations to support participation of Māori with lived experience of disability. This amounts to something close to the exclusion of Māori with lived experience of disability from health and disability sector decision making.

To what extent does disability policy and practice provide culturally appropriate disability services and treatment for those Māori who require it, or provide for Māori led and developed systems and methods of disability care/kaupapa Māori?[227]

229. Māori with lived experience of disability have few options when it comes to accessing disability support services provided by Māori. There are potentially only 33 Māori providers nationwide and geographically there are a number of areas where Māori-provided services are not available.[228]

230. The Crown has not ensured that culturally safe care, reflecting tikanga Māori, is provided across all health and disability services.

What barriers, if any, do Māori experience in accessing disability services and what are existing Crown policies and practices for recognising and addressing any such barriers?[229]

231. Overall, there is strong evidence that the health, well-being, and disability support needs of Māori with lived experience of disability are not being met equitably by the Crown. However, the Crown does not have adequate data monitoring mechanisms in place to be able to quantify the extent of the multiple barriers to access for Māori with lived experience of disability. What is clear are sector-wide responsiveness issues, characterised by a lack of systems and processes, coupled with a lack of accountability on the part of Crown organisations.[230]

To what extent have Crown acts or omissions, if any, contributed to disparities in disability services and outcomes between Māori and non-Māori and how are these recognised and addressed?[231]

232. The significant inequities for Māori in the health and disability system are more pronounced for Māori with lived experience of disability.

233. There are inequities in outcomes, the quality of care received, and in non-evidence-based practices

225 Page 354.

226 Page 356

227 Pages 356-357.

228 Pages 356.

229 Pages 357-358.

230 Page 357.

231 Pages 358-359.

How effective is current monitoring and data collection for identifying and addressing any disparities in disability services and outcomes for Māori?[232]

234. The Crown does not collect adequate data to monitor its performance for Māori with lived experience of disability. The impact of this is that the Crown is not able to fund, plan and design services based on real-time data and insights that would address demonstrated Māori health and disability support needs. It also means that much of the Crown's most sensitive work in the health and disability sector is not routinely scrutinised.

232 Pages 359-362.

Kathleen Smitheram

From: Chris Fry <Chris.Fry@health.govt.nz>
Sent: Wednesday, 26 August 2020 8:23 AM
To: David Meates
Subject: contact[EXTERNAL SENDER]

David,
With Karl still away ill I have been asked to discuss this matter and how we both can take the proposal forward.

Is there a time that best suits you today when I can phone you?

Ngā mihi nui

Kind Regards
Chris Fry
Director, Health Infrastructure – Capital Investment
Chris.Fry@health.govt.nz | **M:** 9(2)(a) DHB Performance, Support & Infrastructure |

http://www.health.govt.nz

From: 9(2)(a) [redacted]; David Meates; 9(2)(a) [redacted]

Cc: Peter.Burt@health.govt.nz; Annie.Davey@health.govt.nz; Jennifer.Lamm@health.govt.nz; Bronwyn.Petrie@health.govt.nz; Jo.Muschamp@health.govt.nz; Jane.Chambers@health.govt.nz; Deborah.Woodley@health.govt.nz; Chrystal.O"Connor@health.govt.nz; Astrid.Koornneef@health.govt.nz; Sharlaine.Chee@health.govt.nz; Karen.Koopu@health.govt.nz; Gerardine.Clifford-Lidstone@health.govt.nz; Leonie.Mercer@health.govt.nz; Toby.Regan@health.govt.nz; David.McCartney@tas.health.nz

Subject: Feedback on draft service specification for the second tranche of COVID-19 funding: Ministry response

Date: Friday, 14 August 2020 8:32:34 AM

Kia ora koutou

Many thanks to all who took time out of your busy schedule to provide feedback on the draft service specification for the second tranche of COVID-19 funding to support PHU contact tracing and preparedness.

Apologies, we are unable to provide the Ministry's response to you this week because the work around COVID-19 has ramped up for colleagues involved in this piece of work. We will endeavour to provide a response soon.

Best wishes

Janet

Janet Chen
Senior Portfolio Manager
Public Health Capability
Public Health
Population Health and Prevention
Ministry of Health
9(2)(a) [redacted]
Fax: 09 580 9001

http://www.moh.govt.nz
mailto:Janet_Chen@moh.govt.nz

From: David Meates
To: Ashley Bloomfield/MOH
Subject: Fwd: Resignation of Sue Nightingale, Chief Medical Officer, Canterbury DHB
Date: Friday, 14 August 2020 7:42:18 PM
Attachments: image001.jpg

Ashley

FYI

David Meates MNZM
CEO Canterbury and West Coast DHBs

Begin forwarded message:

From: Internal Email <Internal.Email@cdhb.health.nz>
Date: 14 August 2020 at 5:13:19 PM NZST
To: Internal Email <Internal.Email@cdhb.health.nz>
Subject: Resignation of Sue Nightingale, Chief Medical Officer, Canterbury DHB

Sent on behalf of David Meates, Chief Executive Officer, Canterbury DHB

Kia ora koutou

It is with regret I advise that Sue Nightingale has resigned from her role as Chief Medical Officer at Canterbury DHB. Sue will continue to work through until the 18th December 2020 reflecting her critical role as the Executive lead for Service Continuity and lead for the COVID-19 response.

Sue joined the executive team in September 2016 after six years as Chief of Psychiatry at our Specialist Mental Health service.

In her time as Chief Medical Officer Sue has championed clinical ethics, equity, clinical governance, quality improvement and putting people receiving treatment and care at the heart of all we do.

Ensuring the consumer voice is heard and improving the consumer experience of health care are behind Sue's passion to continue to do the right thing and make it better for patients.

Under Sue's watch the Clinical Leaders Group has found its voice and had invaluable input into our facilities development programme and they have worked collaboratively across the system to develop and improve patient-centric models of care. Sue chairs the Clinical Board, is involved with the Canterbury Clinical Network and works closely with the Canterbury Primary Response Group.

Sustainability and ensuring decisions on medical supply purchasing are clinically-led

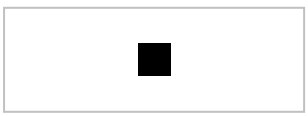
and represent value for money are other areas of responsibility for Sue. She has also worked tirelessly to advocate for the interests of all medical staff.

Sue's leadership has seen her involved in a number of national programmes of work.

On behalf of the Board and EMT, I acknowledge Sue's tremendous contribution to the Canterbury Health System.

Nga mihi
David

David Meates, MNZM
Chief Executive | Canterbury District Health Board and West Coast District Health Board
T: 03 364 4110 (ext 62110) | E: david.meates@cdhb.health.nz
P O Box 1600, Christchurch 8140
www.cdhb.health.nz | www.westcoastdhb.org.nz



Values – A Matou Uara
Care and respect for others - Manaaki me te whakaute i te tangata | Integrity in all we do - Hapai i a matou mahi katoa i runga i te pono | Responsibility for outcomes - Te Takohanga i nga hua

Please forward to any contractors who work in your team

From: David Meates
To: Tony.Lloyd@health.govt.nz
Cc: Michelle_Arrowsmith@moh.govt.nz; Mary Gordon (Executive Director of Nursing)
Subject: Fwd: 9(2) seeking info re consenting/completion for DHB"s Acute hospital block
Date: Tuesday, 13 August 2019 4:12:31 PM
Attachments: image001.png

Hi Tony

This issue isn't going away

Sent from my iPhone

Begin forwarded message:

From: Karalyn van Deursen <Karalyn.Vandeursen@cdhb.health.nz>
Date: 13 August 2019 at 3:55:32 PM NZST
To: David Meates <David.Meates@cdhb.health.nz>, "Mary Gordon (Executive Director of Nursing)" <Mary.Gordon@cdhb.health.nz>, Rob Ojala <Rob.Ojala@cdhb.health.nz>, Angela Mills <Angela.Mills@cdhb.health.nz>
Subject: FW: 9(2)(a) seeking info re consenting/completion for DHB's Acute hospital block

Please see below – 9(2)(a) is following through on this.
David – did you hear back from Tony L re the 9(2)(a) advice?
I will fwd to Kirsty for info.

kvd

From: 9(2)(a) @ccc.govt.nz]
Sent: Tuesday, 13 August 2019 3:49 p.m.
To: Alex Taylor (Communications)
Cc: Karalyn van Deursen
Subject: FW: 9(2)(a) seeking info re consenting/completion for DHB's Acute hospital block

Hi there

FYI.

I will send through our response when it's signed off.

Cheers
9(2)(a)

From: 9(2)(a)
Sent: Tuesday, 13 August 2019 12:44 p.m.
To: 9(2)(a) @ccc.govt.nz>; 9(2)(a) 9(2)(a) @ccc.govt.nz>
Subject: 9(2)(a) seeking info re consenting/completion for DHB's Acute hospital block

Hello 9(2)(a)

There's been a bit of reporting around the wrong pipes being put in at this project, and the catch-up being played since

The public interest is in not being exposed if the pipe has problems as has occurred at Wgtn's relatively new hospital (which also had 9(2)(a) as consulting engineer)

9(2)(a) is aware of concern that your council may be exposed liability-wise if/when the council signs off the COC as compliant with the Building Code, if it is not.

The building was consented on the basis of a specification that did not allow for the pipe, and the multiplicity of brands of pipe, that was installed in it.

Can CCC pls advise:

1. Was the consent amended so that the pipe as installed (and not covered in the original consent) complies?

FYI MOH has referred 9(2)(a) to Watermark certification for the pipes, that it obtained post-installation. The Australian BCB says post-installation WM certification is not possible. So this WM at Chch appears invalid.

This again indicates a shift of risk, to the ratepayer/taxpayer, involving the engineer which failed to stop the wrong pipes being installed in the first place, now being relied on by the MOH (and be extension the DHB if it accepts the building) to approve an invalid certification process for the pipe.

Pls answer question 1, and provide any relevant comment was to this hospital's compliance with Code.

TKS

9(2)(a)
[redacted]

Out of Scope
[redacted]

From: Chris Fry
To: David Meates
Subject: Re: Chch Hospital Campus Masterplan - Tower 3 and Compliance Costs[EXTERNAL SENDER]
Date: Sunday, 30 August 2020 5:58:18 PM
Attachments: image001.jpg

David,
I have reviewed the documents and have a plan for going forward.

Is there some time tomorrow afternoon that suits to discuss?

Chris Fry
MoH

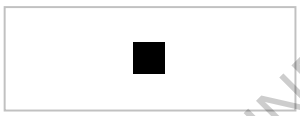
From: David Meates <David.Meates@cdhb.health.nz>
Sent: Thursday, August 27, 2020 5:26:11 PM
To: Chris Fry <Chris.Fry@health.govt.nz>
Cc: Susan Fitzmaurice <Susan.Fitzmaurice@cdhb.health.nz>
Subject: FW: Chch Hospital Campus Masterplan - Tower 3 and Compliance Costs

Hi Chris

Documents as discussed yesterday

Nga mihi

David Meates, MNZM
Chief Executive | Canterbury District Health Board and West Coast District Health Board
T: 03 364 4110 (ext 62110) | E: david.meates@cdhb.health.nz
P O Box 1600, Christchurch 8140
www.cdhb.health.nz | www.westcoastdhb.org.nz



Values – A Matou Uara
Care and respect for others - Manaaki me te whakaute i te tangata | Integrity in all we do - Hapai i a matou mahi katoa i runga i te pono | Responsibility for outcomes - Te Takohanga i nga hua

From: Chris Fry
To: David Meates
Subject: RE: Chch Hospital Campus Masterplan - Tower 3 and Compliance Costs[EXTERNAL SENDER]
Date: Thursday, 27 August 2020 5:48:36 PM
Attachments: image002.jpg
image003.jpg

David,
Thank you and I will starting reviewing tomorrow, and finish possibly over weekend. I will most likely ring you on Monday.

Nga mihi nui

Kind Regards
Chris Fry
Director, Health Infrastructure – Capital Investment
Chris.Fry@health.govt.nz | M: Out of Scope DHB Performance, Support & Infrastructure |
[redacted]
http://www.health.govt.nz

From: David Meates <David.Meates@cdhb.health.nz>
Sent: Thursday, 27 August 2020 5:26 pm
To: Chris Fry <Chris.Fry@health.govt.nz>
Cc: Susan Fitzmaurice <Susan.Fitzmaurice@cdhb.health.nz>
Subject: FW: Chch Hospital Campus Masterplan - Tower 3 and Compliance Costs

Hi Chris

Documents as discussed yesterday

Nga mihi

David Meates, MNZM
Chief Executive | Canterbury District Health Board and West Coast District Health Board
T: 03 364 4110 (ext 62110) | E: david.meates@cdhb.health.nz
P O Box 1600, Christchurch 8140
www.cdhb.health.nz | www.westcoastdhb.org.nz

[redacted]

Values – A Matou Uara
Care and respect for others - Manaaki me te whakaute i te tangata | Integrity in all we do - Hapai i a matou mahi katoa i runga i te pono | Responsibility for outcomes - Te Takohanga i nga hua
****

From: Karl Wilkinson
To: David Meates; John Hazeldine; Rick Barker
Subject: RE: Letter re Mental Health Unit [EXTERNAL SENDER]
Date: Friday, 14 August 2020 4:53:59 PM
Attachments: image001.jpg

Hi David,

Thanks for your email below.

The budget for the investment at West Coast DHB reflects both the expected scope and the expected costs based on unit size and location.

Similar sized and scoped builds have been identified for both Tairawhiti DHB and Bay of Plenty DHB (Whakatane campus). On that basis, no additional Crown funding will be made available for this investment, and hence our advice that the business case must be reformed.

The Health Infrastructure Unit is currently developing a support model for the portfolio of mental health business cases underway. I suggest that we set up a time between your DHB and the HIU so that we determine how we can quickly support you to progress this much needed investment.

Please let us know some convenient times for a discussion, and we can make arrangements to progress.

Regards,

Karl Wilkinson
Director, Health & Infrastructure
DHB Performance, Support & Infrastructure
Mobile: Out of Scope

From: David Meates <David.Meates@cdhb.health.nz>
Sent: Tuesday, 11 August 2020 6:32 pm
To: John Hazeldine <john.hazeldine@health.govt.nz>; 9(2)(a)
Cc: Karl Wilkinson <Karl.Wilkinson@health.govt.nz>
Subject: RE: Letter re Mental Health Unit [EXTERNAL SENDER]

Kia ora John

The Business Case approved by the West Coast DHB was based on this being the minimal requirement for a functional mental health unit on the West Coast. The Business Case approved by the Board was very cognisant of the work that had been done in other parts of the country. The cost per bed of small mental health units are very different from the cost per bed in larger units. The mix of outpatient and inpatient is absolutely consistent with what has been provided on the Coast and the way in which contemporary mental health services are provided.

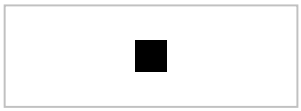
The Board was even more explicit, that any reduction in what they had approved would result in a non-viable mental health service for the Coast and that they could not support further reductions.

It is concerning that a figure of $15m has been identified that has had no rationale to support this

figure and that is at odds with the extensive Detailed Business Case process that has been undertaken on the Coast which has also involved the engagement with the regional mental health services provided via the Canterbury DHB.

Nga mihi

David Meates, MNZM
Chief Executive | Canterbury District Health Board and West Coast District Health Board
T: 03 364 4110 (ext 62110) | E: david.meates@cdhb.health.nz
P O Box 1600, Christchurch 8140
www.cdhb.health.nz | www.westcoastdhb.org.nz



Values – A Matou Uara
Care and respect for others - Manaaki me te whakaute i te tangata | Integrity in all we do - Hapai i a matou mahi katoa i runga i te pono | Responsibility for outcomes - Te Takohanga i nga hua

---

From: Paula Steven <Paula.Steven@health.govt.nz> **On Behalf Of** John Hazeldine
Sent: Monday, 10 August 2020 4:58 PM
To: 9(2)(a) [redacted]
Cc: David Meates <David.Meates@cdhb.health.nz>
Subject: Letter re Mental Health Unit [EXTERNAL SENDER]

Kia ora 9(2)(a) [redacted]

Please see attached letter regarding the mental health unit in Greymouth.

Regards

John

John Hazeldine
Chief Advisor - DHB Performance, Support and Infrastructure
Ministry of Health
Out of Scope [redacted]
http://www.health.govt.nz
mailto:john.hazeldine@health.govt.nz

From: Ashley.Bloomfield@health.govt.nz
To: David Meates
Subject: Re: Resignation of Carolyn Gullery - Executive Director Planning, Funding and Decision Support[EXTERNAL SENDER]
Date: Tuesday, 4 August 2020 8:02:24 AM
Attachments: ATT00001.jpg

Kia ora David, thanks for letting me know, I will make contact with Carolyn
Kind regards
Ashley

Dr Ashley Bloomfield
Director-General of Health

email: ashley.bloomfield@health.govt.nz
Mobile: +Out of Scope
www.health.govt.nz

From: "David Meates" <David.Meates@cdhb.health.nz>
To: "Ashley.Bloomfield@health.govt.nz" <Ashley.Bloomfield@health.govt.nz>
Date: 03/08/2020 04:31 pm
Subject: Resignation of Carolyn Gullery - Executive Director Planning, Funding and Decision Support

Ashley - FYI

Sent on behalf of David Meates, Chief Executive

It is with regret I advise that Carolyn Gullery resigned from her role as Executive Director Planning, Funding and Decision Support for both the Canterbury and West Coast Health Systems. Carolyn will be moving to the UK in September to work with Lightfoot Solutions supporting a number of NHS systems in Wales and England .

Since joining Canterbury District Health Board as Planning and Funding General Manager in 2007, Carolyn has played a significant part in reshaping the way health care is delivered in both Canterbury and the West Coast.

Carolyn has had more than thirty years of health system experience in a variety of strategic and leadership roles for both public and private sector. She has extensive experience in leading complex planning and change processes at a regional and national level together with a proven track record of successfully negotiating health and disability sector contracts at all levels.

Carolyn's career is littered with a number of 'firsts'. Her ability to 'see around corners' and identify solutions that others haven't considered has combined well with her extensive health policy and health alliancing and contracting experience to get a complex health system on track and keep it there.

Carolyn has worked for Canterbury DHB for 13 years but her contribution to the health system in Canterbury, West Coast and New Zealand goes back much further than that. Carolyn came to Canterbury in 1993 to be part of the establishment of the Southern Regional Health Authority. In her time in the various versions of the Health Authorities amongst other things she designed and negotiated the first IPA contract with Pegasus , set up the first budget holding contracts for laboratory and pharmacy services in New Zealand, changed how we received medication to repeat dispensing saving the country $60M in the first year, and led the development of key policies and strategies that impacted on pharmaceuticals, pharmacy and general practice including the development of BPAC and the PharmHouse. She was also the first female and first non-RHA Chief Executive to becomes a Director of PHARMAC in 1997.

As a contractor during the 2000s, she was on the negotiating team for the new PHO agreement (the general practice side) , wrote the policy and implemented CarePlus as an innovative approach for people with complex health and social challenges, operationalised restorative home support in the North Island and was the founding Chief Executive for the largest single PHO , Partnership health . What we have all benefited from though was her

leadership with her clinical colleagues in developing the world - first general practice-led acute admission avoidance programme – 20 years ago and still seen as innovative today. That programme is still with us as the Acute Demand Management Service looking after 35,000 people per annum in a community-based setting and anchoring so much of what we do. That programme was built on trust which set the scene for the development of an integrated adaptive health system based on trust and the alliancing approach.

Carolyn has been instrumental in the development of platforms that support clinicians to do their work including ERMS, HealthPathways, Leading Lights, our Outcomes Framework, the earthquake recovery plan, many hospital business cases , Vision 2020 and the elements to support a truly people-centered health system.

On behalf of the Board and EMT, I acknowledge Carolyn's tremendous contribution to both the Canterbury and West Coast Health Systems and wish her every success for her new role.

Nga mihi

David Meates, MNZM
Chief Executive | Canterbury District Health Board and West Coast District Health Board
T: 03 364 4110 (ext 62110) | E: david.meates@cdhb.health.nz
P O Box 1600, Christchurch 8140
www.cdhb.health.nz | www.westcoastdhb.org.nz

Values – A Matou Uara
Care and respect for others - Manaaki me te whakaute i te tangata | Integrity in all we do - Hapai i a matou mahi katoa i runga i te pono | Responsibility for outcomes - Te Takohanga i nga hua

From: Karl Wilkinson
To: David Meates
Cc: John Hazeldine; John Hansen
Subject: RE: Tower 3 / Compliance
Date: Thursday, 20 August 2020 4:34:15 PM
Attachments: image001.jpg
image002.png
bbc-sinstglt-tp-2018 August 2020.docx

Hello David,
Referring your email, please see below (in red) our responses to your queries. I hope that this helps.
If you do have any further questions or are seeking further clarity on anything here, I would be happy to discuss this directly.
Regards,
Karl

From: David Meates <David.Meates@cdhb.health.nz>
Sent: Wednesday, 19 August 2020 6:29 pm
To: Michelle Arrowsmith <Michelle.Arrowsmith@health.govt.nz>; John Hansen <John.Hansen@cdhb.health.nz>
Cc: Karl Wilkinson <Karl.Wilkinson@health.govt.nz>
Subject: RE: Tower 3 / Compliance

Kia ora Michelle

Just following up regarding the email below. It would be useful to get this clarified as soon as possible. I am conscious of the very tight timelines / timeframes that we are working to.

Nga mihi

David Meates, MNZM
Chief Executive | Canterbury District Health Board and West Coast District Health Board
T: 03 364 4110 (ext 62110) | E: david.meates@cdhb.health.nz
P O Box 1600, Christchurch 8140
www.cdhb.health.nz | www.westcoastdhb.org.nz

Values – A Matou Uara
Care and respect for others - Manaaki me te whakaute i te tangata | Integrity in all we do - Hapai i a matou mahi katoa i runga i te pono | Responsibility for outcomes - Te Takohanga i nga hua

From: David Meates
Sent: Thursday, 13 August 2020 2:34 PM
To: Michelle Arrowsmith <Michelle.Arrowsmith@health.govt.nz>; John Hansen <John.Hansen@cdhb.health.nz>
Cc: Karl Wilkinson <Karl.Wilkinson@health.govt.nz>
Subject: RE: Tower 3 / Compliance

Kia ora Michelle

Thank you for your letter.

It would be helpful to clarify a number of points so that the request that you have sent through can be expedited:

I am assuming that what you are requesting is a summary document that reflects all of the work that has been undertaken to date and previously provided? Correct – the key purpose of the request is to provide a simple, stand-alone document that accurately reflects the preferred solution, rationale, and costs in line with business case requirements. Reference can be made to previous documentation for additional detail and analysis, but the summary should be sufficient to inform a decision-maker who has not reviewed the various previous reports in extensive detail.
I am assuming that the:

- Investment objectives and case for change (Strategic Case)
- Preferred option (Economic Case)
- Financial costing and affordability (Financial Case)
- Proposed procurement and risk sharing approach (Commercial Case)
- Project management strategy (Management Case)

relate to referencing these sections that were part of the MOH / DHB Detailed Programme Business Case and First Tranche Business case? Correct

The clear direction from the MOH was that Tower 3 needed to be consistent with the approved masterplan and that the revised Tower option that was approved by the Board included 5 options and was based purely on affordability. I am therefore assuming that this is what you are seeking to have included in the summary document? Correct

Re the Campus Compliance Works project – are you requiring a separate paper? Yes, a separate paper for the Compliance Works is required.

Again the details that you have requested are contained in the previous information provided and I am assuming that this will be re-packaged in the revised document? Correct. The previous (draft) information that you shared with us substantially addressed these elements. Presentation of this information in alignment with the BC framework will help to ensure that all key elements are fully addressed, and in a consistent format that can be directly assessed alongside the Tower 3 proposal.

Regarding alternative post disaster approaches there are several points to note:

- The minimum compliance is based on Parkside Blocks C&D remaining designated as IL4. However there has never been any intent on trying to strengthen that up to 100% of IL4 rather just doing the minimum compliance including dampers (to deal with shear towers / stairs), panels and passive fire. This facility remains designated as IL 4 gived that critical functiosn such as three / four cath labs are in this facility along with 8 /9 operating theatres – Parkside operating thetreas / cath labs still remains a significant part of the total DHB operating capacity.
- The minimum compliance is based on Parkside a&B being designated as IL3 (inspite of critical IL4 infrastructure running through these facilities). Again the minimum dampers, panels and passive fire remediation.
- None of these options deals with the poor and not fit for purpose clinical space including

toilets / showers which does mean that there is also very limited options for managing infectious diseases etc.

- It is important to note that both Burwood and other facilities in Canterbury and Te Nikau on the West Coast have been significantly downgraded from post disaster IL 4 capability on the basis that Christchurch Hospital was the regional and one of the key national post disaster enabled facilities. This was done to limit the total cost of unnecessary health infrastructure investment elsewhere.
- Private facilities don't play a major part of post disaster enabled facilities. They do however play an important part in the management of responses such as covid-19.

The context and analysis of the DHB's considerations and options in addressing post-disaster planning and response, with respect to the proposal to designate Parkside C&D at IL4 and A&B at IL3, must be captured in the summary paper. Specifically, this should address how facilities available to the DHB (including Hagley coming on line) have been considered in contributing to the DHB's overall Post-disaster response. Where options (such as other off-campus facilities, private) have been assessed and are considered less suitable than the proposed investment in structural works for Parkside, this should be presented in the summary paper with concise rationale.

If you have a template for a "no more than 10 page" document it would be great to get so that what we provide matches expectations. Attached is a short-form template we have previously used, which you can adopt and amend to address the outlined requirements.

I am assuming that what is required should not involve the need for external consultants to re-write and undertake an additional significant piece of work – rather what you are requesting is anchored back into the previous DBC. The documents should be sufficiently self-explanatory and should reflect the key information needed for decision-makers to assess each proposal. The analysis already undertaken and available should be sufficient for this, without involving significant additional work.

Nga mihi

David Meates, MNZM
Chief Executive | Canterbury District Health Board and West Coast District Health Board
T: 03 364 4110 (ext 62110) | E: david.meates@cdhb.health.nz
P O Box 1600, Christchurch 8140
www.cdhb.health.nz | www.westcoastdhb.org.nz

Values – A Matou Uara
Care and respect for others - Manaaki me te whakaute i te tangata | Integrity in all we do - Hapai i a matou mahi katoa i runga i te pono | Responsibility for outcomes - Te Takohanga i nga hua

---

From: Michelle Arrowsmith <Michelle.Arrowsmith@health.govt.nz>
Sent: Monday, 10 August 2020 12:59 PM
To: John Hansen <John.Hansen@cdhb.health.nz>
Cc: David Meates <David.Meates@cdhb.health.nz>; Karl Wilkinson <Karl.Wilkinson@health.govt.nz>
Subject: Tower 3 / Compliance

Kia ora Sir John

Please see attached letter regarding Christchurch Hospital Tower 3 and Campus Compliance Works projects.

Nga mihi
Michelle

Michelle Arrowsmith
Deputy Director General | DHB Performance, Support and Infrastructure | Ministry of Health
E: michelle.arrowsmith@health.govt.nz | 9(2)(a) [redacted]
http://www.health.govt.nz

[redacted]

****
Statement of confidentiality: This e-mail message and any accompanying attachments may contain information that is IN-CONFIDENCE and subject to legal privilege.
If you are not the intended recipient, do not read, use, disseminate, distribute or copy this message or attachments.
If you have received this message in error, please notify the sender immediately and delete this message.
****

This e-mail message has been scanned for Viruses and Content and cleared by the Ministry of Health's Content and Virus Filtering Gateway

<Agency logo>

<Agency Name>

<Project or Programme Name>

Single Stage Light Business Case – Template

This template is to be used for Small and Medium projects seeking approval from the Health Infrastructure Investment Package.

Prepared by:	
Prepared for:	
Date:	
Version:	
Status:	

Better Business Cases
Single Stage Light Business Case Template

Document Control

Document Information

	Position
Document ID	
Document owner	
Issue date	
Filename	

Document History

Version	Issue Date	Changes

Document Review

Role	Name	Review Status
Project Manager		

Document Sign-off

Role	Name	Sign-off Date
Project Manager		
Senior Responsible Owner/ Project Executive		

Purpose

Describe the investment proposal at the beginning in two or three sentences. State what decision-makers are being asked to consider or decide.

This business justification case seeks formal approval to invest up to [$x.xxx million/000] in the years [20xx/xx] to ….

This business case follows the Treasury Better Business Cases guidance and is organised around the five case model.

Strategic Case

Describe and explain the problem

What benefits will be achieved from the investment ie investment objectives and case for change.

Economic Case

Identify options that were considered and assessment criteria used.

Identify a preferred option which represents the best value for money.

Describe and explain the solution

Financial Case

How much will this cost? Is the DHB contributing to the project cost (and if so, please specify)?

Assess the whole of life costs. Be clear on assumptions.

What allowance has been made for contingency?

What types of cost are involved, and over what period? Over how long?

If it's multiple year and multiple revenue stream, fill in the table below. Be clear on any capital requirement from the Crown.

	2019/20	2020/21	2021/22	2022/23	……..	Total
Capital expenditure						
Operating expenditure						
Total expenditure						
Revenue						
Capital required						
Capital required						
Operating required						

Commercial Case

What things are needed to be purchased/procured?

How will this be purchased/procured?

What commercial (not project) risks are there? How will those risks be dealt with?

Management Case

How complex will the delivery be?

Who is ultimately responsible for this project? What mechanisms are there to keep them and stakeholders appraised of problems?

How will this project achieve the benefits, and how will benefits be managed and evaluated?

What risks are there? What's the mechanism for monitoring and seeking resolution?

Summarise the project management, benefits and risk management and post project evaluation arrangements.

Next Steps

Please provide an update of procurement / construction timelines and other key milestones.

From: Jo.Waugh@health.govt.nz on behalf of Ashley.Bloomfield@health.govt.nz
To: David Meates
Subject: Influenza Vaccination Coverage for Maori[EXTERNAL SENDER]
Date: Monday, 24 August 2020 3:05:51 PM
Attachments: 24082020142933-0001.pdf

Dear David

Please find attached a letter from Ashley re the above.

Kind regards

Jo

Jo Waugh
Executive Assistant to

Dr Ashley Bloomfield
Director-General of Health

email: ashley.bloomfield@health.govt.nz
Mobile: Out of Scope
www.health.govt.nz

MINISTRY OF HEALTH
MANATŪ HAUORA

133 Molesworth Street
PO Box 5013
Wellington 6140
New Zealand
T +64 4 496 2000

David Meates, Chief Executive, Canterbury DHB
david.meates@cdhb.govt.nz

27 August 2020

Dear David,

Re: Influenza Vaccination Coverage for Māori

Thank you for your response to my letter regarding your efforts to deliver the influenza vaccination programme and your coverage for kaumātua Māori aged 65 and over.

Targeting improved coverage for kaumātua Māori

It is reassuring to hear about the work that your team is undertaking to support improved coverage for kaumātua Māori, particularly the work to support Te Puawaitanga Trust in their Kaupapa Māori Flu Programme. I am sure that there will be many learnings from this work. I ask that you continue to encourage your immunisation team to work in partnership with your Tumu Whakarae and Māori providers to ensure that these learnings can be utilised to improve service provision for Māori across immunisation services, including for the current National Measles Immunisation Campaign.

Coverage Issues

While the Ministry understands and appreciates your concerns about using census population projection data as a denominator for coverage, PHO enrolment data shows that only 84 percent of Māori in Canterbury are enrolled with a PHO compared to 98 percent of Pacific peoples and 96 percent Other. Therefore, using PHO enrolment data as a denominator is likely to overestimate coverage for kaumātua Māori and mask inequities for those who are not accessing primary care.

I note your comment on the current inability of DHBs to produce an influenza immunisation coverage report by ethnicity. To support DHBs with this, the Ministry of Health has been providing weekly NIR influenza coverage reports by ethnicity, DHB and age group throughout the 2020 influenza vaccination programme. I am pleased to be able to reassure you that in future years this reporting will be available to all DHBs through the Qlik app.

Ngā mihi

Dr Ashley Bloomfield
Director-General of Health

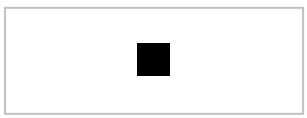
From: David Meates
To: John Hazeldine
Subject: FW: Letter from Sir John Hansen, Chair Canterbury DHB re Tower 3
Date: Monday, 24 August 2020 4:19:00 PM
Attachments: Letter to Chair CIC-2020-05-07.pdf
Letter to Chair CIC - Board Resolution.pdf
Letter to Chair CIC - CDHB Campus Master Plan Implementation Option A May 2020.pdf
image001.jpg
image002.jpg
image003.jpg

John

Information provided to Murray Milner CIC and his emailed response as discussed.

Nga mihi

David Meates, MNZM
Chief Executive | Canterbury District Health Board and West Coast District Health Board
T: 03 364 4110 (ext 62110) | E: david.meates@cdhb.health.nz
P O Box 1600, Christchurch 8140
www.cdhb.health.nz | www.westcoastdhb.org.nz



Values – A Matou Uara
Care and respect for others - Manaaki me te whakaute i te tangata | Integrity in all we do - Hapai i a matou mahi katoa i runga i te pono | Responsibility for outcomes - Te Takohanga i nga hua

From: Murray Milner [mailto:murray.milner[redacted]
Sent: Thursday, 7 May 2020 4:18 p.m.
To: Susan Fitzmaurice <Susan.Fitzmaurice@cdhb.health.nz>
Cc: Michelle.Arrowsmith@health.govt.nz; ashley.bloomfield@health.govt.nz
Subject: RE: Letter from Sir John Hansen, Chair Canterbury DHB re Tower 3

Susan,

Thank you for the response and associated attachments.

I have requested that this item be discussed at the next meeting of the CIC.

Thanks
Murray

From: Susan Fitzmaurice
Sent: Thursday, 7 May 2020 3:42 p.m.
To: 'murray.milner@[redacted]

Cc: 'Michelle.Arrowsmith@health.govt.nz' <Michelle.Arrowsmith@health.govt.nz>; 'ashley.bloomfield@health.govt.nz' <ashley.bloomfield@health.govt.nz>
Subject: Letter from Sir John Hansen, Chair Canterbury DHB re Tower 3

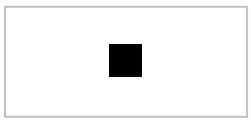
Good afternoon Murray

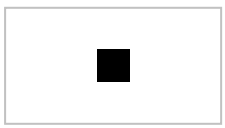
Please find attached letter and attachments from our Chair, Sir John Hansen in response to your letter of 11 December 2019.

Regards

Susan Fitzmaurice | EA to David Meates, Chief Executive
Canterbury District Health Board and West Coast District Health Board

03 364 4110 | susan.fitzmaurice@cdhb.health.nz
P O Box 1600, Christchurch
www.cdhb.health.nz | www.westcoastdhb.org.nz





Values – A Matou Uara
Care and respect for others - Manaaki me te whakaute i te tangata | Integrity in all we do - Hapai i a matou mahi katoa i runga i te pono | Responsibility for outcomes - Te Takohanga i nga hua

Canterbury
District Health Board
Te Poari Hauora ō Waitaha

CHAIRMAN'S OFFICE

Corporate Office
1st Floor
32 Oxford Terrace
CHRISTCHURCH

Mobile: 021688745
e-mail: john.hansen@cdhb.health.nz

7 May 2020

Murray Milner
Delegated Chair
Capital Investment Committee

Dear Murray

In response to your letter dated 11 December 2019 the Board requested that management explore a range of options for the Board to consider with regard to progressing Tower 3. These options ranged from $154m through to $214m.

The Board at its meeting on 1 May 2020 agreed to recommend to CIC Reduced Cost Tower 3 option A at $154 million (Board resolution attached). There had also been consultation with the Ministry of Health prior to the Board meeting who had advised that they would support option A.

The Board requests CIC to approve Option A at $154 million. To support this request, I have attached the details of Option A that was presented to the Board and informed our decision process. If it is helpful to CIC, we can make the other options available.

If the capital allocation is approved, we look forward to working with the Ministry of Health to further develop Option A to detailed planning and contracting. The Board noted that we understand the Ministry of Health actively supports Option A.

We would also look to work with the Ministry of Health to develop a contractual/delivery approach that will avoid some of the complications that arose from the Hagley development. We think there is general agreement, from all involved in that development, that this is required.

We advise as an essential part of this work we will be working with the Ministry of Health to bring together a plan for the necessary compliance work for the Christchurch Campus. This will be progressed as a matter of urgency.

Yours sincerely

Hon Sir John Hansen *KNZM*
Chairman

Copy to: Ashley Bloomfield, Director-General, MoH
Michelle Arrowsmith, DDG DHB Performance Support & Infrastructure, MoH

JH2020/1001

CANTERBURY DISTRICT HEALTH BOARD

Canterbury District Health Board
Te Poari Hauora o Waitaha

EXCERPT FROM PUBLIC EXCLUDED SPECIAL BOARD MEETING MINUTES
01 May 2020

Item 1
Christchurch Hospital Campus Master Plan - Tower 3 and Compliance Costs

Resolution (xx/20)
(Moved: Sir John Hansen/Seconded: Gabrielle Huria - carried)
(Jo Kane and Andrew Dickerson voted against)

"That the Board:

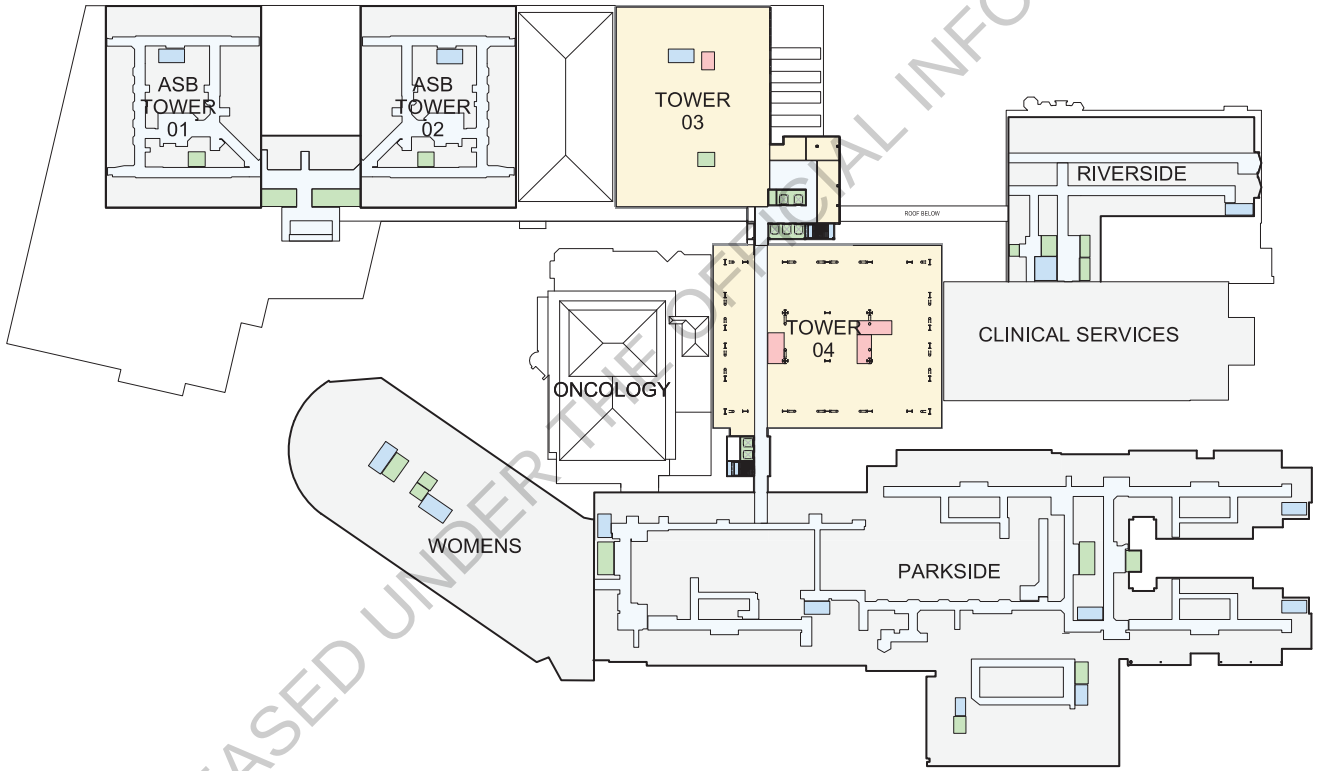
i. approves the $154m Campus Masterplan Tranche 1 Reduced Cost Tower 3 Option A (containing 5 ward floors -2 floors fitted out and 3 floors shelled) and recommend it to MOH and CIC for approval."

"The Board notes:

- the agreed Christchurch Hospital Campus Master Plan was developed in partnership between the Canterbury DHB and the Ministry of Health;
- the agreed Christchurch Hospital Campus plan Programme Detailed Business Case and First Tranche Detailed Business Case included agreed population, service demand and capacity forecasts;
- that the original request to the Capital Investment Committee was for $437.78m to deliver a 6-ward level Tower 3 and the design for Tower 4 and Central Podium plus enabling works and minimal refurbishment of Parkside and associated facilities. This had been agreed in partnership with the Ministry of Health, Management and Clinicians as required to meet the needs of the Canterbury community and function as a tertiary provider supporting service provision across the lower North Island and South Island;
- the Board, while accepting the capital constraints for the sector is disappointed that only $150m has been allocated to this project;
- that the Clinical Leaders Group did not support this option as they consider it does not provide the capacity required to deliver and sustain current service levels and impacts on the future configuration of the Christchurch Hospital Masterplan delivery;
- the time critical nature regarding the commencement of the T3 project and the critical need to move forward with urgency; and
- that future capital investment will be required within a short period of time to ensure the agreed capacity needs are met."

Canterbury DHB Campus Master Plan Implementation: Reduced Cost Option A

May 2020



Canterbury District Health Board
Te Poari Hauora ō Waitaha

Purpose of this paper

The Christchurch Campus Master Plan Detailed Business Case (DBC) and Programme Business Case (PBC) authored by the Ministry of Health (MOH) and approved by CDHB Board were delivered to HRPG and Capital Investment Committee late 2019.

Recent communications from Ministry of Health highlights a significant shortfall between the scope of the first tranche of work described in the DBC against capital available from the Crown – in financial terms, the DBC option 1b (an already truncated version of CDHB's preferred option) included a Crown capital funding envelope of $387m and CDHB funding of $51m from the earthquake programme of works; total capital value $438m noted in the DBC. MOH indicates Crown capital available for the DBC's Tranche 1 works is significantly less than the $387m required under the 1b scope.

This paper is a high level document examining alternative solutions to that described in the DBC in light of the funding signal. It details a significant reduction in scope; the associated capital savings as well as clinical / operational impacts on CDHB, knock on effects for future campus development; and impacts on future theatre / inpatient bed demand and programme.

Structure and Inputs

In preparing this paper CDHB has engaged project managers previously involved in the Campus Master Planning process, and who also provided advice to CDHB on the Ministry's DBC / PBC.

In addition, a number of the initiatives in the reduced scope proposal have required inputs from health planners/architects, quantity surveyors, programmer and structural engineers, all of whom have had experience in the earlier DBC process, so were aware of the constraints and complexities of the campus and the impact of choices and options considered.

Input has also been sought from senior CDHB management and clinicians in reviewing the reduced scope of works and how this impacts day to day running of the facility as well as some of the longer term impacts. The proposed reduced scope of work in a number of areas has significant negative clinical and operational impacts for staff and patients; guidance from these individuals has attempted to mitigate some of these impacts.

The following pages describe the Ministry DBC Option 1b (noted as preferred in that document) and then the reduced scope options including costs, pros and cons, programme, bed/theatre demand and impact on future masterplan activities.

The final narrative describes consequences clinically, operationally and for future redevelopment due to the change in scope of work in the reduced scope option and how the delayed packages of work might be completed in conjunction with Tranche 2 works Central Podium and Tower 4 (CT4). The last slides show the proposed new delivery programme for the first Tranche of work.

DBC Background

During the drafting of the jointly sponsored (MOH and CDHB) DBC / PBC document; the goal was to maintain the enabling works to the existing campus, T3 and CT4 design and construction to be considered under one funding package; a process that would allow the removal of possible roadblocks to unlock the campus and assist the CDHB in delivering the necessary bed and theatre capacity as demand increases.

MOH indicated that in order to align with the national capital funding envelope it would not be possible to undertake all these elements of work under a single tranche and the DBC was updated to portray several separately funded tranches within a wider Program Business Case. The facilities enabling work, T3 delivery and co-design of CT4 originally constituted Tranche 1 of this.
As part of the later development of the Tranche 1 DBC document; it was clear that costings associated with this scope of work were higher than had been anticipated. The CDHB entered into a process with the MOH consultant team to significantly reduce the quantum of heavy / moderate refurbishments within the existing facilities. The result was the creation of DBC Option 1b, that being the current scope associated with the Crown's $387m capital fund. The compromises however were contingent on agreement for a fast track program to achieve CT4 (the construction of which was latterly moved to Tranche 2). Clinical leaders involved in this process have agreed, for example, in a reduction in scope for the Parkside earthquake repair and redevelopment alone from circa $150m down to $80m on the basis that the limited capital available should be focussed more prudently on new facilities.

The other significant factor affecting redevelopment costs and scope is time. The 2012 CDHB Hagley DBC stated further future work was required on the campus and needed to be delivered by 2022 to keep pace with growing demand – current programme puts T3 completion at 2025 incurring additional cost escalation and capacity concerns; it is also worth noting that the population projection in 2012 for 2020 has been exceeded by 60,000 (a population expansion that places the region currently at levels not anticipated until 2024).

The demand forecasting (both beds and theatres) has been through five separate external reviews between MOH/CDHB and expert consultants and is now agreed as per the DBC.

The Capital Investment Committee's response to the submission of the jointly sponsored DBC has forced the DHB to examine what might be achieved with a further reduced option. This process has increased operational compromises and raised potential hurdles for future Campus development over and above what the CDHB had previously agreed to.

The reduced scope version from CDHB has retained critical elements that are essential to 'unlock' the site and are consistent with the overall agreed campus masterplan objectives, however a number of these changes are making the implementation of the masterplan more difficult and expensive. It should also be noted that essential enabling works (passive fire and earthquake repairs are now removed from the scope) will inevitably incur escalation costs as a result of this deferment.

Overview of Reduced Scope Option A

Options A items excluded from the DBC Option 1b; these are described in detail in the Option A sheet and associated financial spreadsheets following but at a high level these include:

- deleting preparatory work around CT4
- removing work associated with offices and café in Hagley building
- leaving the existing food services building in service
- reducing the D space on Tower 3
- removal of DBC allowances for seismic strengthening and all of the passive fire compliance (to be funded via an alternative source)

Option A – Ministry of Health Capital Funding Estimate **$154m**.

- Tower 3 containing 5 ward floors; 2 floors fitted out and 3 shelled (64 beds supplied at project completion with capacity to have 160 beds total once fully fitted out)

Key areas of reduced scope

- Remove proposed work in currently unallocated space in lower ground floor Hagley earmarked in the DBC as clinical support space for anaesthetics, radiology and surgical staff – resulting in those staff maintaining their current dislocated positions across campus and placing them further from their new orbit of work in the Hagley facility.
- Not undertaking elements of work within Tranche 1 portion of the DBC associated with enabling a smoother / faster handover to Tranche 2 (CT4); removing CT4 design process, infrastructure re-routing work and ground improvement works.
- Leave the main hospital kitchen and Great Escape Café in the Food Services Building – this removes the kitchen fit-out work in lower ground floor of Women's, the new café in the lower ground floor of Hagley and demolition of the Food Services Building. This is a key enabling step for CT4.
- Ward Tower 3 requires an area of clinical support 'D' space – similar to the shared space between the existing towers on Hagley; this area allows for shared treatment / office and staff facilities' efficiencies between ward blocks and is vital to the operation of the adjacent wards. The reduced scope option is looking to design and build D space as is only required for T3 and to create that space on top of the existing podium. This option reduces the area required to be built as part of Tranche 1 and makes that reduced area cheaper to build as it does not require ground improvement, foundations, base isolators and footprint up to the top of the podium.
- Removal of allowances for passive fire and seismic compliance works to existing facilities. This will require a separate funding stream.

To reiterate, this Option contains a further and aggressive reduction in scope when compared to the preferred DBC Option 1b for facilities in Parkside, Riverside and Clinical Services Building; where in many cases teams will be moving in to perform a different clinical or technical function with little or no remodelling/renovation in a facility that is already not fit for purpose.

Some of the works no longer occurring (namely passive fire and seismic) are still required to be completed and will have to be funded under a separate model. The operational impacts of implementing this Option has not yet been fully assessed but once the reductions in scope (to match the revised capital constraints) are understood, CDHB will be in a position to gauge the effects on day to day operations on staff and patients.

CDHB Further Reduced Option A (T3 5 wards, 2 fit out & 3 shell)

Capital Cost:

MOH Funding: $154m

Inclusions (high level):

- Construct Tower 3, 5 ward floors; fit out 2 floors (64 beds and shell 3 floors, inclusive of reduced "D" space)
- ~~Full design of new Central Building and Tower 4~~
- ~~In ground Services for new Central building and Tower 4~~
- ~~Infrastructure for new Central building and Tower 4~~
- Respiratory Lab relocation
- Move Medical Physics from Riverside West
- ~~Move Kitchen into Women's Building~~
- ~~Build offices in Hagley LGF for Anaesthetics, Radiology and Surgical staff~~
- Move Clinical Engineering from Riverside
- Move Blood Bank closer to Hagley
- ~~Relocate Apheresis~~
- ~~Move staff and public café to Hagley~~
- ~~Demolish old Food Services Building~~
- Fit out new DOSA and Recovery
- ~~Move terminations to Women's~~
- ~~Move Child Protection Team~~
- Build new Docks
- Move ENT/Audiology from Riverside West
- Convert theatre into Cath Lab
- Gastro compliance works
- Relocate Sleep unit
- ~~Passive fire remediation – existing facilities (Tranche 1)~~
- Create holding area in LGF Hagley

Annual Bed Demand Projections – Adult Inpatient and Short Stay:

Orange = bed capacity exceeded frequently during the year

Red = bed deficit

Financial year	Capacity	Gap
2019/20	594	17
2020/21	610	14
2021/22	571	-42
2022/23	571	-60
2023/24	571	-78
2024/25	(T3) 558	-109
2025/26	558	-129
2026/27	558	-151
2027/28	558	-172
2028/29	558	-193
2029/30	558	-213
2030/31	558	-224

Annual Theatre Demand Projections:

Orange = theatre capacity exceeded frequently during the year = outsource

Red = theatre deficit

Financial year	Capacity	Gap
2022/23	26	0
2023/24	26	-1
2024/25	26	-2
2025/26	26	-2
2026/27	26	-3
2027/28	26	-3
2028/29	26	-4
2029/30	26	-5
2030/31	26	-5

Programme:

Occupy Tower 3 - January 2025

No further projects are anticipated after this in this option

Approvals: 127

This option is based on an approval for the project prior to June 2020 that allows the full scope included to commence at the start of June 2020. Any delay to the approval will result in an extension of the programme by the amount of the delay. It is also predicated on required structural works in Hagley commencing immediately.

Additional major items removed (over and above inclusions list on this page):

- Redesign of proposed "D" space from approximately 5,000m2 down to approximately 1,800m2
- Furniture Fittings and Equipment allowances reduced
- Escalation and programme reviewed
- Remove top three levels of ward fit-out leaving serviced shell for future completion
- Refer to relevant spreadsheets in this document for further detail

Master Plan Consequences:

- We have not located departments in places that would impede the eventual agreed Master Plan implementation
- Tranche 2 contained half of the passive fire remediation money and as such the implementation of remediation works will be delayed with known issues remaining outstanding. This option notes Tranche 1 fire remediation is separately funded
- Original Master Plan staging had CT4 being occupied so that seismic and fire repairs could be completed in Parkside and now this sequence cannot be followed. This may require outsourced theatre and bed resource to provide capacity during implementation
- Following stages will all be delayed as opportunity to design CT4 and enabling works will form the next critical path

Operational Consequences:

- Central Building and Tower 4 construction is assumed to be on hold as are all following Tranches of work such as Hagley Annex
- We have assumed the three shell wards in Tower 3 will not be completed in the near future
- Agreed bed and theatre demand will not be met
- Many services and wards will have to move into old unsuitable areas and remain there without improvements for potentially ten years

Option A - $154m Reduced Cost Option - Tower 3 with 5 levels of wards with two fitted out and three shelled out for future fit-out without passive fire and seismic compliance costs										
	2020	2021	2022	2023	2024	2025	2026	2027	Total	
Scope of work	9(2)(i)(j)									Notes:
Passive Fire										See attached details for areas altered
Decanting/staging										As per original allowances
Tower 4										Tower 4 design, infrastructure and ground improvement deleted
Riverside										See attached details for areas altered
Parkside										See attached details for areas altered
Clinical Services Building										See attached details for areas altered
Food Services Building										See attached details for areas altered
Christchurch Women's Hospital										See attached details for areas altered
Hagley (incl new Tower3)										See attached details for areas altered
Total Revised DBC Scope Crow Capital										

Option A - $154m Reduced Cost Option - Tower 3 with 5 levels of wards with two fitted out and three shelled out for future fit-out without passive fire and seismic compliance costs

Building	Item	Original DBC Allowance $000	$154m Option changes $000	Notes
Passive Fire	Passive - Fire Parkside, CSB and Riverside	9(2)(i)(j)		Passive fire removed and to be funded elsewhere
	Original Allowance/Reduction totals			
Passive Fire	**Total allowance for original DBC and $154m option**			
Central Building and Tower 4	Tower 4 design, infrastructure and ground improvement deleted			All works in relation to new Central Building and Tower 4 are removed. This will mean that eventual building will take longer to deliver and will cost more due to lost ability to design with Tower 3
	Original Allowance/Reduction totals			
Central Building and Tower 4	**Total allowance for original DBC and $154m option**			
Riverside	Original DBC allowance			
	East block electrical switchboard upgrade			Leave in as required to enable old wards to be used as workspace
	Central block strengthening of columns			Assume there is another funding spice for a component of the earthquake repairs - arbitrary deduction to meet capital envelope
	Fire compliance for Central and East			To be funded from Passive Fire item above and future fit-out projects
	BOH of docks, storage and mobility services etc			Allowance retained
	Medical Physics equipment and workroom relocation from West			Allowance retained
	Docks reloaction			Allowance retained
	Travel and Engineering			Leave in as required to make tight cost planning in new areas work
	EQ and deferred maintenance work allowance by RLB			Reduced allowance and if exceeded it will require a different funding stream
	Dirty dock relocation external works			Allowance retained
Riverside	**Original Allowance/Reduction totals**			
Riverside	**Total allowance for original DBC and $154m option**			
Parkside	Original DBC allowance			
	Compliance strengthening and panel works allowances			Assume that all panel works are completed under CDHB panel budget and that shear towers are completed under budget below. Leave nominal allowance for any uncovered issues during construction.
	Shear towers strengthening and rework			No allowance for shear tower seismic works originally omitted by DBC
	Med Physics relocation			Allowance retained
	Clinical Engineering relocation			Allowance retained
	Apheresis relocation			Deleted from all options to meet capital constraints
	Blood Bank relocation			Deleted bulk of allowance as will be tenant fit-out of new space. Allowance retained for warm shell work
	Cath Lab			Allowance retained and decision made that funding for FF & E will BAU
	Sleep/Infusions/MDU/FOH relocation into AMAU			Allowance retained
	Reconfiguration of main entrance			Allowance retained
	DOSA/Per Op and Post Op reconfigurations			Allowance retained
	Med Physiology Hub into old ED plus OT/Physio			Allowance retained
	Allied health and speech language therapy relocation			Allowance retained
	Paeds outpatients relocation minor reconfiguration			Allowance retained
	Signage and sundries allowance			Allowance arbitrary reduction of $2.5m to meet constrained capital
	Clean dock relocation			Removed as suspect it is a double up from a previous version
Parkside	**Original Allowance/Reduction totals**			
	Total allowance for original DBC and $154m option			

		9(2)(i)(j)	
Clinical Services Building	Original DBC allowance		
	Air handling capacity increase for Gastro compliance		Allowance retained
	Strengthen shear walls and roof structure		Consultants previous reccomended that $4,720k worth of work required but as building is assessed as 35% of IL3 NBS it is not earthquake prone and no works proposed here. If work is required a separate funding stream will be needed
	Compliance strengthening to level 3 columns		Consultants previous reccomended that $346k worth of work required but as building is assessed as 35% of IL3 NBS it is not earthquake prone and no works proposed here. If work is required a separate funding stream will be needed
	Relocate HV switch and routing		Removed from all options as not required now that the Food Services building is being retained
	Upgrade medical gas zone valves for Gastro compliance		Allowance retained
	Compliance strengthening to level 3 columns		Assume there is another funding source for a component of the earthquake repairs - arbitrary deduction to meet capital envelope
	ENT/Audio relocation		Allowance retained
	Gastro minor expansion		Allowance retained
	Signage and sundries allowance		Allowance arbitrary reduction of $1.389m to meet constrained capital. Allowance needs to be retained for missed Orthopeadic alterations and Plastice minor reconfigurations
	Earthquake remediation allowance		Assume there is another funding source for a component of the earthquake repairs - arbitrary deduction to meet capital envelope. Retain $200k for work uncovered requiring remediation
Clinical Services Building	**Original Allowance/Reduction totals**		
Clinical Services Building	**Total allowance for original DBC and $154m option**		
Food Services Building	Original DBC allowance		
	Relocate substation to Women's Building		Work no longer required as Food Services building not demolished
	Passive Fire remediation		As this building was originally to be demolished and now must remain it will require passive fire remediation works. This work is not allowed under this project and must be funded elsewhere.
	Demolish Food Services Building		Building no longer demolished. Issues with existing building such as non-complying ground floor slab in kitchen are to be dealt with as BAU items
Food Services Building	**Original Allowance/Reduction totals**		
Food Services Building	**Total allowance for original DBC and $154m option**		
Women's	Original DBC allowance		
	Kitchen relocation from Food Services building		Allowance removed
	Passive fire remediation		Consultants advise that remedial passive fire work required however these are excluded here and an work will need a separate funding stream
	Seismic repairs		Consultants advise that remedial seismic work is required however these are excluded here and an work will need a separate funding stream
	Lyndhurst (terminations) relocated		Allowance removed
	Child Protection team relocation		Allowance removed
Women's	**Original Allowance/Reduction totals**		
Women's	**Total allowance for original DBC and $154m option**		
Hagley	Original DBC allowance		
	Workspace for Radiology and Surgical teams		Allowance removed. Workspace to be in old buildings without alteration
	Workspace for Anesthetic teams		Allowance removed. Workspace to be in old buildings without alteration
	Café fit-out		Allowance removed as Food Services build remaining
	BOH holding area in LGF		Allowance retained as operationally required
	Tower 3		
			Reduced "D" space redesign
			Delete sixth level of wards from tower
			Shell 3 levels of ward fit-out
Hagley	**Original Allowance/Reduction totals**		
Hagley	**Total allowance for original DBC and $154m option**		
	Total of above DBC 1b items		
	Add original DBC decanting/staging allowance		
	Total allowance for original DBC and $154m option		Cross checks with DBC $387m
	Total value removed from DBC Preferred Opiton 1b		

CDHB Further Reduced Options: Omissions and Consequences

Clinical impacts

- Clinical services will have to move into areas with a changed clinical function (e.g. old ED) with little or no refurbishment and remain there for the foreseeable future
- Clinical services will continue to look after patients in buildings with poor facilities including unacceptable ablutions, infection control separation and inadequate space to avoid increasing length of stay from hospital-acquired acute sarcopenia (rapid loss of muscle strength in elder population due to bedrest. This occurs rapidly and can significantly affect mobility after even a few days. Adequate mobilisation and physiotherapy can offset this providing there is adequate space at bedside and nearby to enable. This is also known as “pyjama paralysis”.)
- Broader separation of high acuity patients across the campus will require additional resource to manage the emergency response
- The hospital will have an extended period of ongoing disruption from construction activities due to the programme delays and extensions
- The Parkside operating theatres (which is over a third of all theatres on the campus) will be over 35 years old and will not have had an upgrade in their lifetime. The delay to the delivery of CT4 and Hagley Annex will further extend their operating life and make it extremely hard to upgrade them due to numbers constraint and also not wishing to invest in an ageing facility

Redevelopment impacts

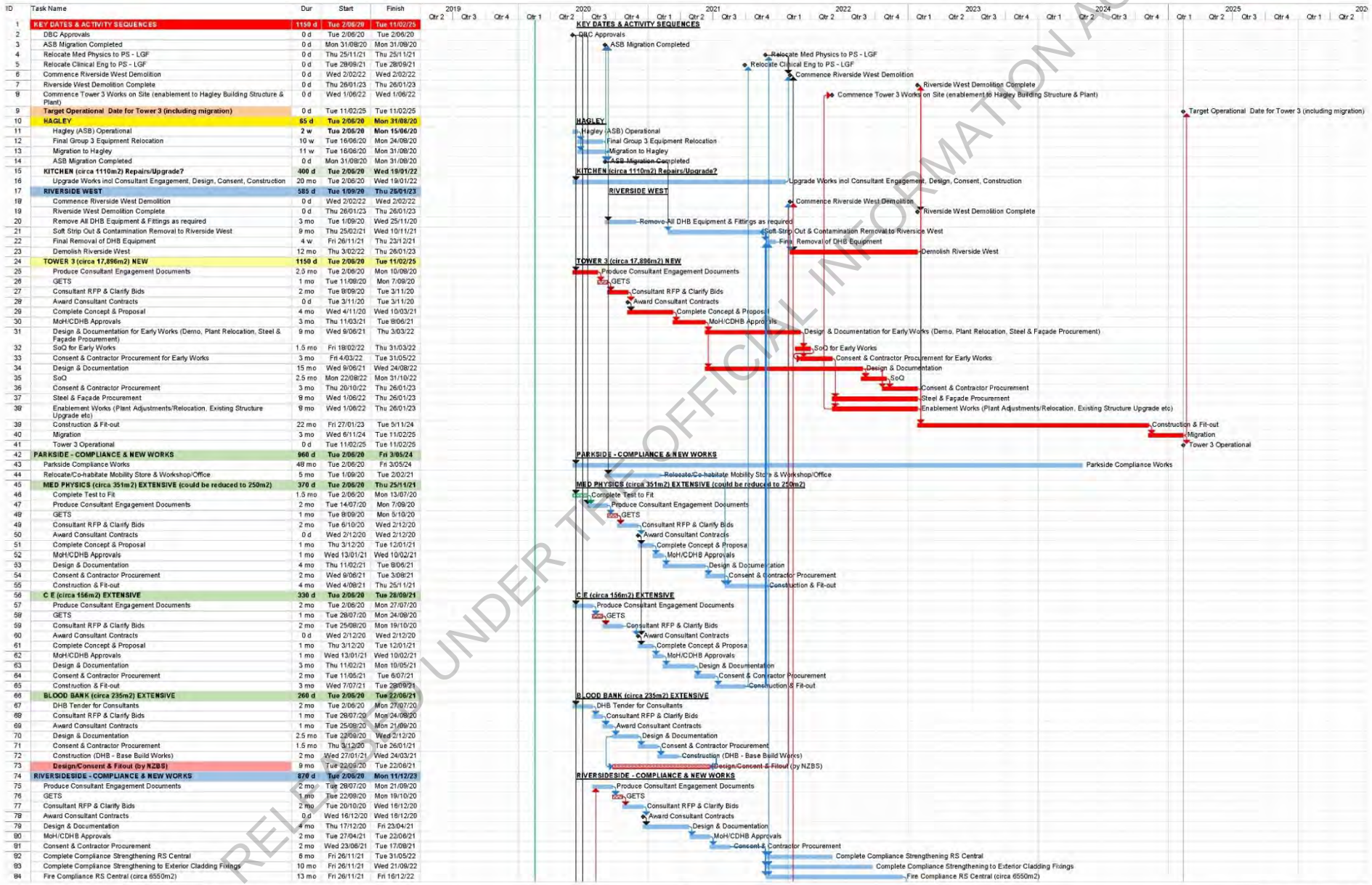
- Lost synergies of designing T3 and CT4 together; design will start afresh for subsequent works (both CT4 and deferred enabling works) once approval is given and this will reset the critical path rather than enabling this now
- Fire egress in T3 will be vertical and not horizontal until CT4 is completed and they are paired up (T3 effectively operating as an ‘orphan’ ward for an unknown period)
- Retaining the food service building will require additional capital to repair the main kitchen floor to achieve building compliance and funds to complete the fire compliance works that were not previously budgeted for
- Because we will not have additional bed and theatre capacity by the dates originally planned there will be additional bed demand from population growth that will impact upon the ability to complete compliance works particularly on the warded floors
- Budgets for T3 works do not include for achieving a Green Star certified facility
- CT4 will cost more than currently noted in DBC as the building will need to be larger and more complex to meet T3 and delay to the programme will increase escalation
- We must avoid the risk of short-term cost-driven solutions derailing Masterplan as this agreed document maps the only foreseeable pathway for the future development of the Campus
- There will be the need to carry out additional works to the old building stock to keep them compliant due to delays in operational exit
- Removal of tranche 1 fire compliance funding to the existing facilities will further complicate incorporating this work with the overall redevelopment
- There will be an increased risk relating to the current facility non-compliance issues with the regulating bodies (e.g. CCC and passive fire, façade panels) due to delays in appropriate mitigation
- The ongoing delays in the handover of the new Hagley Building is reducing the available time to complete the Parkside compliance works. Delays to this will end up pushing back additional bed supply required for additional demand

Operational impacts

- Significant bed and theatre capacity shortfall to match agreed demand
- Operational inefficiencies of workforce being dislocated from their primary orbit of clinical work results in increasing resource required or diminished output.
- Parkside’s second block of funding for fire compliance was in Tranche 2 – CT4 ($16m) – with uncertain timeframes associated with CT4 this work will require additional outplaced theatre work to enable and a funding stream
- Loss of operational efficiencies of horizontally paired wards [T3 and CT4]
- Continued separation of operationally synergic services e.g. Terminations and Women’s procedural spaces; ENT and Maxillofacial service; Medical physics and Clinical engineering services.
- Tranche 2 scope includes provision for additional cath labs to meet demand – this will now require a further operating theatre in Parkside to be converted – further reducing the number of available theatres
- Parkside will continue clinical functions operating in an unsuitable environment for the foreseeable future
- 5 ward floors (Options A & B) rather than 6 ward floors under Options C,D&E reduces the tower ultimate capacity by 32 and dictates CT4 being similar (this will accelerate need for podium and Tower 5)

CHCH HOSPITAL CAMPUS
MASTER PLANNING VERSION 02 (reduced scope - 200215)

WOODS HARRIS Consulting Limited

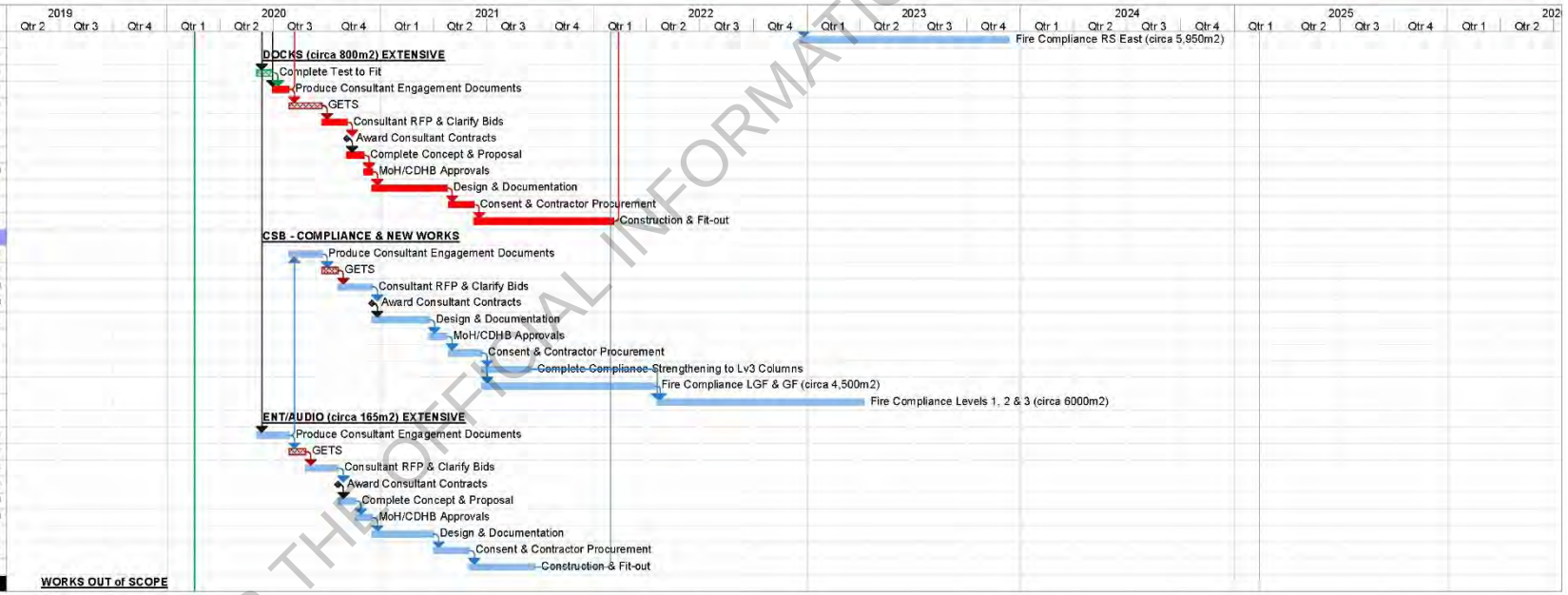


ID	Task Name	Dur	Start	Finish
1	KEY DATES & ACTIVITY SEQUENCES	1150 d	Tue 2/06/20	Tue 11/02/25
2	DBC Approvals	0 d	Tue 2/06/20	Tue 2/06/20
3	ASB Migration Completed	0 d	Mon 31/08/20	Mon 31/08/20
4	Relocate Med Physics to PS - LGF	0 d	Thu 25/11/21	Thu 25/11/21
5	Relocate Clinical Eng to PS - LGF	0 d	Tue 28/09/21	Tue 28/09/21
6	Commence Riverside West Demolition	0 d	Wed 2/02/22	Wed 2/02/22
7	Riverside West Demolition Complete	0 d	Thu 26/01/23	Thu 26/01/23
8	Commence Tower 3 Works on Site (enablement to Hagley Building Structure & Plant)	0 d	Wed 1/06/22	Wed 1/06/22
9	Target Operational Date for Tower 3 (including migration)	0 d	Tue 11/02/25	Tue 11/02/25
10	HAGLEY	65 d	Tue 2/06/20	Mon 31/08/20
11	Hagley (ASB) Operational	2 w	Tue 2/06/20	Mon 15/06/20
12	Final Group 3 Equipment Relocation	10 w	Tue 16/06/20	Mon 24/08/20
13	Migration to Hagley	11 w	Tue 16/06/20	Mon 31/08/20
14	ASB Migration Completed	0 d	Mon 31/08/20	Mon 31/08/20
15	KITCHEN (circa 1110m2) Repairs/Upgrade?	400 d	Tue 2/06/20	Wed 19/01/22
16	Upgrade Works incl Consultant Engagement, Design, Consent, Construction	20 mo	Tue 2/06/20	Wed 19/01/22
17	RIVERSIDE WEST	585 d	Tue 1/09/20	Thu 25/01/23
18	Commence Riverside West Demolition	0 d	Wed 2/02/22	Wed 2/02/22
19	Riverside West Demolition Complete	0 d	Thu 26/01/23	Thu 26/01/23
20	Remove All DHB Equipment & Fittings as required	3 mo	Tue 1/09/20	Wed 25/11/20
21	Soft Strip Out & Contamination Removal to Riverside West	9 mo	Thu 25/02/21	Wed 10/11/21
22	Final Removal of DHB Equipment	4 w	Fri 26/11/21	Thu 23/12/21
23	Demolish Riverside West	12 mo	Thu 3/02/22	Thu 26/01/23
24	TOWER 3 (circa 17,896m2) NEW	1150 d	Tue 2/06/20	Tue 11/02/25
25	Produce Consultant Engagement Documents	2.5 mo	Tue 2/06/20	Mon 10/08/20
26	GETS	1 mo	Tue 11/08/20	Mon 7/09/20
27	Consultant RFP & Clarify Bids	2 mo	Tue 8/09/20	Tue 3/11/20
28	Award Consultant Contracts	0 d	Tue 3/11/20	Tue 3/11/20
29	Complete Concept & Proposal	4 mo	Wed 4/11/20	Wed 10/03/21
30	MoH/CDHB Approvals	3 mo	Thu 11/03/21	Tue 8/06/21
31	Design & Documentation for Early Works (Demo, Plant Relocation, Steel & Façade Procurement)	9 mo	Wed 9/06/21	Thu 3/03/22
32	SoQ for Early Works	1.5 mo	Fri 18/02/22	Thu 31/03/22
33	Consent & Contractor Procurement for Early Works	3 mo	Fri 4/03/22	Tue 31/05/22
34	Design & Documentation	15 mo	Wed 9/06/21	Wed 24/08/22
35	SoQ	2.5 mo	Mon 22/08/22	Mon 31/10/22
36	Consent & Contractor Procurement	3 mo	Thu 20/10/22	Thu 26/01/23
37	Steel & Façade Procurement	9 mo	Wed 1/06/22	Thu 26/01/23
38	Enablement Works (Plant Adjustments/Relocation, Existing Structure Upgrade etc)	9 mo	Wed 1/06/22	Thu 26/01/23
39	Construction & Fit-out	22 mo	Fri 27/01/23	Tue 5/11/24
40	Migration	3 mo	Wed 6/11/24	Tue 11/02/25
41	Tower 3 Operational	0 d	Tue 11/02/25	Tue 11/02/25
42	PARKSIDE - COMPLIANCE & NEW WORKS	960 d	Tue 2/06/20	Fri 3/05/24
43	Parkside Compliance Works	48 mo	Tue 2/06/20	Fri 3/05/24
44	Relocate/Co-habitate Mobility Store & Workshop/Office	5 mo	Tue 1/09/20	Tue 2/02/21
45	MED PHYSICS (circa 351m2) EXTENSIVE (could be reduced to 250m2)	370 d	Tue 2/06/20	Thu 25/11/21
46	Complete Test to Fit	1.5 mo	Tue 2/06/20	Mon 13/07/20
47	Produce Consultant Engagement Documents	2 mo	Tue 14/07/20	Mon 7/09/20
48	GETS	1 mo	Tue 8/09/20	Mon 5/10/20
49	Consultant RFP & Clarify Bids	2 mo	Tue 6/10/20	Wed 2/12/20
50	Award Consultant Contracts	0 d	Wed 2/12/20	Wed 2/12/20
51	Complete Concept & Proposal	1 mo	Thu 3/12/20	Tue 12/01/21
52	MoH/CDHB Approvals	1 mo	Wed 13/01/21	Wed 10/02/21
53	Design & Documentation	4 mo	Thu 11/02/21	Tue 8/06/21
54	Consent & Contractor Procurement	2 mo	Wed 9/06/21	Tue 3/08/21
55	Construction & Fit-out	4 mo	Wed 4/08/21	Thu 25/11/21
56	C E (circa 156m2) EXTENSIVE	330 d	Tue 2/06/20	Tue 28/09/21
57	Produce Consultant Engagement Documents	2 mo	Tue 2/06/20	Mon 27/07/20
58	GETS	1 mo	Tue 28/07/20	Mon 24/08/20
59	Consultant RFP & Clarify Bids	2 mo	Tue 25/08/20	Mon 19/10/20
60	Award Consultant Contracts	0 d	Wed 2/12/20	Wed 2/12/20
61	Complete Concept & Proposal	1 mo	Thu 3/12/20	Tue 12/01/21
62	MoH/CDHB Approvals	1 mo	Wed 13/01/21	Wed 10/02/21
63	Design & Documentation	3 mo	Thu 11/02/21	Mon 10/05/21
64	Consent & Contractor Procurement	2 mo	Tue 11/05/21	Tue 6/07/21
65	Construction & Fit-out	3 mo	Wed 7/07/21	Tue 28/09/21
66	BLOOD BANK (circa 235m2) EXTENSIVE	260 d	Tue 2/06/20	Tue 22/06/21
67	DHB Tender for Consultants	2 mo	Tue 2/06/20	Mon 27/07/20
68	Consultant RFP & Clarify Bids	1 mo	Tue 28/07/20	Mon 24/08/20
69	Award Consultant Contracts	1 mo	Tue 25/08/20	Mon 21/09/20
70	Design & Documentation	2.5 mo	Tue 22/09/20	Wed 2/12/20
71	Consent & Contractor Procurement	1.5 mo	Thu 3/12/20	Tue 26/01/21
72	Construction (DHB - Base Build Works)	2 mo	Wed 27/01/21	Wed 24/03/21
73	Design/Consent & Fitout (by NZBS)	9 mo	Tue 22/09/20	Tue 22/06/21
74	RIVERSIDESIDE - COMPLIANCE & NEW WORKS	870 d	Tue 2/06/20	Mon 11/12/23
75	Produce Consultant Engagement Documents	2 mo	Tue 28/07/20	Mon 21/09/20
76	GETS	1 mo	Tue 22/09/20	Mon 19/10/20
77	Consultant RFP & Clarify Bids	2 mo	Tue 20/10/20	Wed 16/12/20
78	Award Consultant Contracts	0 d	Wed 16/12/20	Wed 16/12/20
79	Design & Documentation	4 mo	Thu 17/12/20	Fri 23/04/21
80	MoH/CDHB Approvals	2 mo	Tue 27/04/21	Tue 22/06/21
81	Consent & Contractor Procurement	2 mo	Wed 23/08/21	Tue 17/09/21
82	Complete Compliance Strengthening RS Central	8 mo	Fri 26/11/21	Tue 31/05/22
83	Complete Compliance Strengthening to Exterior Cladding Fixings	10 mo	Fri 26/11/21	Wed 21/09/22
84	Fire Compliance RS Central (circa 6550m2)	13 mo	Fri 26/11/21	Fri 16/12/22

CHCH HOSPITAL CAMPUS
MASTER PLANNING VERSION 02 (reduced scope - 200215)

WOODS HARRIS Consulting Limited

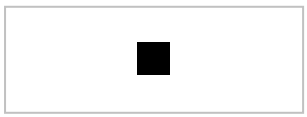
ID	Task Name	Dur	Start	Finish
85	Fire Compliance RS East (circa 5,950m2)	12 mo	Mon 19/12/22	Mon 11/12/23
86	**DOCKS (circa 800m2) EXTENSIVE**	**410 d**	**Tue 2/06/20**	**Wed 2/02/22**
87	Complete Test to Fit	1 mo	Tue 2/06/20	Mon 29/06/20
88	Produce Consultant Engagement Documents	1 mo	Tue 30/06/20	Mon 27/07/20
89	GETS	2 mo	Tue 28/07/20	Mon 21/09/20
90	Consultant RFP & Clarify Bids	1.5 mo	Tue 22/09/20	Tue 3/11/20
91	Award Consultant Contracts	0 d	Tue 3/11/20	Tue 3/11/20
92	Complete Concept & Proposal	1 mo	Wed 4/11/20	Wed 2/12/20
93	MoH/CDHB Approvals	2 w	Thu 3/12/20	Wed 16/12/20
94	Design & Documentation	4 mo	Thu 17/12/20	Fri 23/04/21
95	Consent & Contractor Procurement	1.5 mo	Tue 27/04/21	Tue 8/06/21
96	Construction & Fit-out	8 mo	Wed 9/06/21	Wed 2/02/22
97	**CSB - COMPLIANCE & NEW WORKS**	**700 d**	**Tue 2/06/20**	**Fri 7/04/23**
98	Produce Consultant Engagement Documents	2 mo	Tue 28/07/20	Mon 21/09/20
99	GETS	1 mo	Tue 22/09/20	Mon 19/10/20
100	Consultant RFP & Clarify Bids	2 mo	Tue 20/10/20	Wed 16/12/20
101	Award Consultant Contracts	0 d	Wed 16/12/20	Wed 16/12/20
102	Design & Documentation	3 mo	Thu 17/12/20	Wed 24/03/21
103	MoH/CDHB Approvals	1 mo	Thu 25/03/21	Fri 23/04/21
104	Consent & Contractor Procurement	2 mo	Tue 27/04/21	Tue 22/06/21
105	Complete Compliance Strengthening to Lv3 Columns	3 mo	Wed 23/06/21	Tue 14/09/21
106	Fire Compliance LGF & GF (circa 4,500m2)	10 mo	Wed 23/06/21	Thu 14/04/22
107	Fire Compliance Levels 1, 2 & 3 (circa 6000m2)	12 mo	Tue 19/04/22	Fri 7/04/23
108	**ENT/AUDIO (circa 165m2) EXTENSIVE**	**325 d**	**Tue 2/06/20**	**Tue 21/09/21**
109	Produce Consultant Engagement Documents	2 mo	Tue 2/06/20	Mon 27/07/20
110	GETS	1 mo	Tue 28/07/20	Mon 24/08/20
111	Consultant RFP & Clarify Bids	2 mo	Tue 25/08/20	Mon 19/10/20
112	Award Consultant Contracts	0 d	Mon 19/10/20	Mon 19/10/20
113	Complete Concept & Proposal	1 mo	Tue 20/10/20	Wed 18/11/20
114	MoH/CDHB Approvals	1 mo	Thu 19/11/20	Wed 16/12/20
115	Design & Documentation	3.25 mo	Thu 17/12/20	Wed 31/03/21
116	Consent & Contractor Procurement	2 mo	Thu 1/04/21	Mon 31/05/21
117	Construction & Fit-out	4 mo	Tue 1/06/21	Tue 21/09/21
118	**WORKS OUT of SCOPE**	**1033 d**	**Mon 20/05/19**	**Thu 3/08/23**



From: David Meates
To: Chris Fry
Subject: FW: Tower 3 / Compliance
Date: Wednesday, 26 August 2020 5:15:00 PM
Attachments: image001.jpg
image002.png
bbc-sinstglt-tp-2018 August 2020.docx

Nga mihi

David Meates, MNZM
Chief Executive | Canterbury District Health Board and West Coast District Health Board
T: 03 364 4110 (ext 62110) | E: david.meates@cdhb.health.nz
P O Box 1600, Christchurch 8140
www.cdhb.health.nz | www.westcoastdhb.org.nz



Values – A Matou Uara
Care and respect for others - Manaaki me te whakaute i te tangata | Integrity in all we do - Hapai i a matou mahi katoa i runga i te pono | Responsibility for outcomes - Te Takohanga i nga hua

---

From: David Meates
Sent: Sunday, 23 August 2020 2:05 PM
To: John Hazeldine <john.hazeldine@health.govt.nz>
Cc: John Hansen <John.Hansen@cdhb.health.nz>
Subject: FW: Tower 3 / Compliance

John

I understand from our Chair that you are now the contact person in relation to progressing the Tower 3 / compliance issues.

Earlier this year, the Chair received a letter from the acting Chair CIC confirming receipt of the revised Board approved Tower 3 business case and that this was going to the next CIC meeting. We have received no confirmation that this occurred and that CIC in fact reviewed this case as CDHB has received no feedback.

As you will recall the MOH commissioned and the joint MOH / CDHB detailed programme business case and Detailed First Tranche Business case was approved by the CDHB Board and was submitted to the CIC in 2019. These business cases were developed as part of the agreed process and outcomes from the "Truth and Reconciliation" process that built on the MOH / DHB agreed Christchurch Hospital Campus Masterplan.

The revised Tower 3 proposal was created based on CIC not agreeing to the joint MOH / CDHB Detailed Business Case in November 2019. It was agreed with the MOH that the revised Tower 3 proposal needed to be consistent with the Masterplan and NOT compromise any further development of the campus and that this proposal would be treated as an addendum to the

Detailed Business Case i.e. it did not need a further Business case to be developed as the following had already been developed:

- Investment objectives and case for change (Strategic Case)
- Preferred option (Economic Case)
- Financial costing and affordability (Financial Case)
- Proposed procurement and risk sharing approach (Commercial Case)
- Project management strategy (Management Case)

We are unclear as to what is now expected to be resubmitted in relation to Tower 3. We had been previously informed that there was no further information. What we have already provided, is in more detail that would normally be submitted to CIC for approval. Therefore being asked to provide a summary single stage business case again for Tower 3 when this has already been submitted to CIC as requested when the MOH / CDHB joint Detailed business case was rejected by CIC in November 2019 is somewhat puzzling.

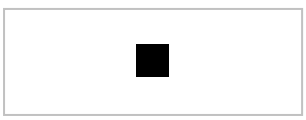
RE the Compliance proposal, we had provided a very detailed outline of the minimal compliance required to meet regulatory minimum standards (as requested). This was provided to the MOH many months ago and the DHB was advised that this contained all the detail and rationale that was required. Again this was a very minimal compliance programme that explicitly does not meet or deal with any of the clinical and patient / staff safety issues that have been very clearly articulated in the MOH commissioned joint MOH / CDHB detailed programme and first tranche business cases.

There is no further work that we can undertake to provide any more rationale or justification than has already been developed / provided from the 2012 Cabinet approved DBC, the 2016 PWC draft revised campus DBC, the MOH / DHB approved campus masterplan, the MOH commissioned joint MOH / DHB 2019 Detailed Programme and Detailed First Tranche Business Cases, the revised Board approved Tower 3 Business Case (2020) and the Board approved minimum compliance case (2020).

From what you and your team have now requested, my understanding is that we are largely representing the Board approved revised Tower 3 and the revised Board approved compliance proposals back to CIC. Can you please confirm that.

Nga mihi

David Meates, MNZM
Chief Executive | Canterbury District Health Board and West Coast District Health Board
T: 03 364 4110 (ext 62110) | E: david.meates@cdhb.health.nz
P O Box 1600, Christchurch 8140
www.cdhb.health.nz | www.westcoastdhb.org.nz



Values – A Matou Uara
Care and respect for others - Manaaki me te whakaute i te tangata | Integrity in all we do - Hapai i a matou mahi katoa i runga i te pono | Responsibility for outcomes - Te Takohanga i nga hua

From: Karl Wilkinson <Karl.Wilkinson@health.govt.nz>
Sent: Thursday, 20 August 2020 4:31 PM
To: David Meates <David.Meates@cdhb.health.nz>
Cc: John Hazeldine <john.hazeldine@health.govt.nz>; John Hansen <John.Hansen@cdhb.health.nz>
Subject: RE: Tower 3 / Compliance

Hello David,
Referring your email, please see below (in red) our responses to your queries. I hope that this helps.
If you do have any further questions or are seeking further clarity on anything here, I would be happy to discuss this directly.
Regards,
Karl

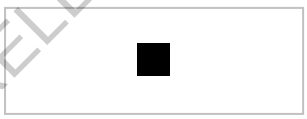
From: David Meates <David.Meates@cdhb.health.nz>
Sent: Wednesday, 19 August 2020 6:29 pm
To: Michelle Arrowsmith <Michelle.Arrowsmith@health.govt.nz>; John Hansen <John.Hansen@cdhb.health.nz>
Cc: Karl Wilkinson <Karl.Wilkinson@health.govt.nz>
Subject: RE: Tower 3 / Compliance

Kia ora Michelle

Just following up regarding the email below. It would be useful to get this clarified as soon as possible. I am conscious of the very tight timelines / timeframes that we are working to.

Nga mihi

David Meates, MNZM
Chief Executive | Canterbury District Health Board and West Coast District Health Board
T: 03 364 4110 (ext 62110) | E: david.meates@cdhb.health.nz
P O Box 1600, Christchurch 8140
www.cdhb.health.nz | www.westcoastdhb.org.nz



Values – A Matou Uara
Care and respect for others - Manaaki me te whakaute i te tangata | Integrity in all we do - Hapai i a matou mahi katoa i runga i te pono | Responsibility for outcomes - Te Takohanga i nga hua

---

From: David Meates
Sent: Thursday, 13 August 2020 2:34 PM
To: Michelle Arrowsmith <Michelle.Arrowsmith@health.govt.nz>; John Hansen <John.Hansen@cdhb.health.nz>

Cc: Karl Wilkinson <Karl.Wilkinson@health.govt.nz>
Subject: RE: Tower 3 / Compliance

Kia ora Michelle

Thank you for your letter.

It would be helpful to clarify a number of points so that the request that you have sent through can be expedited:

I am assuming that what you are requesting is a summary document that reflects all of the work that has been undertaken to date and previously provided? Correct – the key purpose of the request is to provide a simple, stand-alone document that accurately reflects the preferred solution, rationale, and costs in line with business case requirements. Reference can be made to previous documentation for additional detail and analysis, but the summary should be sufficient to inform a decision-maker who has not reviewed the various previous reports in extensive detail.
I am assuming that the:

- Investment objectives and case for change (Strategic Case)
- Preferred option (Economic Case)
- Financial costing and affordability (Financial Case)
- Proposed procurement and risk sharing approach (Commercial Case)
- Project management strategy (Management Case)

relate to referencing these sections that were part of the MOH / DHB Detailed Programme Business Case and First Tranche Business case? Correct

The clear direction from the MOH was that Tower 3 needed to be consistent with the approved masterplan and that the revised Tower option that was approved by the Board included 5 options and was based purely on affordability. I am therefore assuming that this is what you are seeking to have included in the summary document? Correct

Re the Campus Compliance Works project – are you requiring a separate paper? Yes, a separate paper for the Compliance Works is required.

Again the details that you have requested are contained in the previous information provided and I am assuming that this will be re-packaged in the revised document? Correct. The previous (draft) information that you shared with us substantially addressed these elements. Presentation of this information in alignment with the BC framework will help to ensure that all key elements are fully addressed, and in a consistent format that can be directly assessed alongside the Tower 3 proposal.

Regarding alternative post disaster approaches there are several points to note:

- The minimum compliance is based on Parkside Blocks C&D remaining designated as IL4. However there has never been any intent on trying to strengthen that up to 100% of IL4 rather just doing the minimum compliance including dampers (to deal with shear towers / stairs), panels and passive fire. This facility remains designated as IL 4 gived that critical functiosn such as three / four cath labs are in this facility along with 8 /9 operating

theatres – Parkside operating thetreas / cath labs still remains a significant part of the total DHB operating capacity.

- The minimum compliance is based on Parkside a&B being designated as IL3 (inspite of critical IL4 infrastructure running through these facilities). Again the minimum dampers, panels and passive fire remediation.
- None of these options deals with the poor and not fit for purpose clinical space including toilets / showers which does mean that there is also very limited options for managing infectious diseases etc.
- It is important to note that both Burwood and other facilities in Canterbury and Te Nikau on the West Coast have been significantly downgraded from post disaster IL 4 capability on the basis that Christchurch Hospital was the regional and one of the key national post disaster enabled facilities. This was done to limit the total cost of unnecessary health infrastructure investment elsewhere.
- Private facilities don't play a major part of post disaster enabled facilities. They do however play an important part in the management of responses such as covid-19.

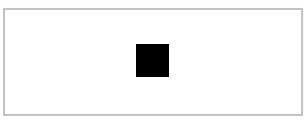
The context and analysis of the DHB's considerations and options in addressing post-disaster planning and response, with respect to the proposal to designate Parkside C&D at IL4 and A&B at IL3, must be captured in the summary paper. Specifically, this should address how facilities available to the DHB (including Hagley coming on line) have been considered in contributing to the DHB's overall Post-disaster response. Where options (such as other off-campus facilities, private) have been assessed and are considered less suitable than the proposed investment in structural works for Parkside, this should be presented in the summary paper with concise rationale.

If you have a template for a "no more than 10 page" document it would be great to get so that what we provide matches expectations. Attached is a short-form template we have previously used, which you can adopt and amend to address the outlined requirements.

I am assuming that what is required should not involve the need for external consultants to re-write and undertake an additional significant piece of work – rather what you are requesting is anchored back into the previous DBC. The documents should be sufficiently self-explanatory and should reflect the key information needed for decision-makers to assess each proposal. The analysis already undertaken and available should be sufficient for this, without involving significant additional work.

Nga mihi

David Meates, MNZM
Chief Executive | Canterbury District Health Board and West Coast District Health Board
T: 03 364 4110 (ext 62110) | E: david.meates@cdhb.health.nz
P O Box 1600, Christchurch 8140
www.cdhb.health.nz | www.westcoastdhb.org.nz



Values – A Matou Uara
Care and respect for others - Manaaki me te whakaute i te tangata | Integrity in all we do - Hapai i a matou mahi katoa i runga i te pono | Responsibility for outcomes - Te Takohanga i nga hua

From: Michelle Arrowsmith <Michelle.Arrowsmith@health.govt.nz>
Sent: Monday, 10 August 2020 12:59 PM
To: John Hansen <John.Hansen@cdhb.health.nz>
Cc: David Meates <David.Meates@cdhb.health.nz>; Karl Wilkinson <Karl.Wilkinson@health.govt.nz>
Subject: Tower 3 / Compliance

Kia ora Sir John

Please see attached letter regarding Christchurch Hospital Tower 3 and Campus Compliance Works projects.

Nga mihi
Michelle

Michelle Arrowsmith
Deputy Director General | DHB Performance, Support and Infrastructure | Ministry of Health
E: michelle.arrowsmith@health.govt.nz | M: Out of Scope |
http://www.health.govt.nz

****
Statement of confidentiality: This e-mail message and any accompanying attachments may contain information that is IN-CONFIDENCE and subject to legal privilege.
If you are not the intended recipient, do not read, use, disseminate, distribute or copy this message or attachments.
If you have received this message in error, please notify the sender immediately and delete this message.
****

This e-mail message has been scanned for Viruses and Content and cleared by the Ministry of Health's Content and Virus Filtering Gateway

<Agency logo>

<Agency Name>

<Project or Programme Name>

Single Stage Light Business Case – Template

This template is to be used for Small and Medium projects seeking approval from the Health Infrastructure Investment Package.

Prepared by:	
Prepared for:	
Date:	
Version:	
Status:	

Better Business Cases
Single Stage Light Business Case Template

Document Control

Document Information

	Position
Document ID	
Document owner	
Issue date	
Filename	

Document History

Version	Issue Date	Changes

Document Review

Role	Name	Review Status
Project Manager		

Document Sign-off

Role	Name	Sign-off Date
Project Manager		
Senior Responsible Owner/ Project Executive		

Purpose

Describe the investment proposal at the beginning in two or three sentences. State what decision-makers are being asked to consider or decide.

This business justification case seeks formal approval to invest up to [$x.xxx million/000] in the years [20xx/xx] to ….

This business case follows the Treasury Better Business Cases guidance and is organised around the five case model.

Strategic Case

Describe and explain the problem

What benefits will be achieved from the investment ie investment objectives and case for change.

Economic Case

Identify options that were considered and assessment criteria used.

Identify a preferred option which represents the best value for money.

Describe and explain the solution

Financial Case

How much will this cost? Is the DHB contributing to the project cost (and if so, please specify)?

Assess the whole of life costs. Be clear on assumptions.

What allowance has been made for contingency?

What types of cost are involved, and over what period? Over how long?

If it's multiple year and multiple revenue stream, fill in the table below. Be clear on any capital requirement from the Crown.

	2019/20	2020/21	2021/22	2022/23	……..	Total
Capital expenditure						
Operating expenditure						
Total expenditure						
Revenue						
Capital required						
Capital required						
Operating required						

Commercial Case

What things are needed to be purchased/procured?

How will this be purchased/procured?

What commercial (not project) risks are there? How will those risks be dealt with?

Management Case

How complex will the delivery be?

Who is ultimately responsible for this project? What mechanisms are there to keep them and stakeholders appraised of problems?

How will this project achieve the benefits, and how will benefits be managed and evaluated?

What risks are there? What's the mechanism for monitoring and seeking resolution?

Summarise the project management, benefits and risk management and post project evaluation arrangements.

Next Steps

Please provide an update of procurement / construction timelines and other key milestones.

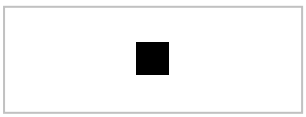
From: David Meates
To: Chris Fry
Cc: Susan Fitzmaurice
Subject: FW: Chch Hospital Campus Masterplan - Tower 3 and Compliance Costs
Date: Thursday, 27 August 2020 5:26:00 PM
Attachments: May 2020 - Chch Hospital Campus Master Plan - Tower 3 and Compliance Costs.zip
May 2020 - Letter to Chair CIC - CDHB Campus Master Plan Implementation Option A May 2020.zip
April 2020 Chch Hospital Campus Master Plan - Tower 3 and Compliance Costs.zip
image001.jpg

Hi Chris

Documents as discussed yesterday

Nga mihi

David Meates, MNZM
Chief Executive | Canterbury District Health Board and West Coast District Health Board
T: 03 364 4110 (ext 62110) | E: david.meates@cdhb.health.nz
P O Box 1600, Christchurch 8140
www.cdhb.health.nz | www.westcoastdhb.org.nz



Values – A Matou Uara
Care and respect for others - Manaaki me te whakaute i te tangata | Integrity in all we do - Hapai i a matou mahi katoa i runga i te pono | Responsibility for outcomes - Te Takohanga i nga hua

Canterbury
District Health Board
Te Poari Hauora ō Waitaha

CHAIRMAN'S OFFICE

Corporate Office
1st Floor
32 Oxford Terrace
CHRISTCHURCH

Mobile: 021688745
e-mail: john.hansen@cdhb.health.nz

7 May 2020

Murray Milner
Delegated Chair
Capital Investment Committee

Dear Murray

In response to your letter dated 11 December 2019 the Board requested that management explore a range of options for the Board to consider with regard to progressing Tower 3. These options ranged from $154m through to $214m.

The Board at its meeting on 1 May 2020 agreed to recommend to CIC Reduced Cost Tower 3 option A at $154 million (Board resolution attached). There had also been consultation with the Ministry of Health prior to the Board meeting who had advised that they would support option A.

The Board requests CIC to approve Option A at $154 million. To support this request, I have attached the details of Option A that was presented to the Board and informed our decision process. If it is helpful to CIC, we can make the other options available.

If the capital allocation is approved, we look forward to working with the Ministry of Health to further develop Option A to detailed planning and contracting. The Board noted that we understand the Ministry of Health actively supports Option A.

We would also look to work with the Ministry of Health to develop a contractual/delivery approach that will avoid some of the complications that arose from the Hagley development. We think there is general agreement, from all involved in that development, that this is required.

We advise as an essential part of this work we will be working with the Ministry of Health to bring together a plan for the necessary compliance work for the Christchurch Campus. This will be progressed as a matter of urgency.

Yours sincerely

Hon Sir John Hansen *KNZM*
Chairman

Copy to: Ashley Bloomfield, Director-General, MoH
Michelle Arrowsmith, DDG DHB Performance Support & Infrastructure, MoH

Canterbury District Health Board
P O Box 1600, Christchurch 8140, New Zealand

CHRISTCHURCH HOSPITAL CAMPUS MASTER PLAN -TOWER 3 AND COMPLIANCE COSTS

Canterbury District Health Board
Te Poari Hauora ō Waitaha

TO: **Chair and Members, Canterbury District Health Board**

ACCOUNTABILITY: **David Meates, Chief Executive Officer**

DATE: **16 April 2020**

Report Status – For:	Decision	☑	Noting	☐	Information	☐

1. ORIGIN OF THE REPORT

The Christchurch Hospital Campus Master Plan was co-commissioned by the Ministry of Health (*MoH*) and the Canterbury District Health Board (*CDHB*) to inform both the Programme Business Case (*PBC*) and the Detailed Business Case (*DBC*) Tranche 1 scope for this campus.

The Master Plan includes population demand for tertiary hospital services through to 2031.

The PBC covers the facilities demand and location of services from 2020 through to 2031.

The resulting DBC covered the first tranche of facilities development outlining the options considered, identifying the preferred option (Option 1b) and outlining the economic, financial, strategic, commercial and management cases. The DBC preferred Option 1b required $387m of Crown funds and $51m of CDHB funds – totalling $438m.

The MoH (via the Capital Investment Committee (*CIC*)) has advised the CDHB that there is insufficient capital available nationally to support the preferred Option 1b and requested that alternative reduced cost Options are developed for consideration. The MoH has also requested that the main Campus known compliance issues (limited to passive fire and seismic) are included within the revised scopes and estimates.

This paper provides a suite of potential reduced cost Options for the delivery of the new Hagley Tower 3 (*T3*), associated enabling packages and seismic/passive fire compliance works along with a recommendation.

2. RECOMMENDATION

That the Board:

i. notes that the CDHB DBC preferred Option 1 for Campus Masterplan Implementation requiring $777m of Crown funds and $51m of CDHB funds – totalling $828m was not adopted due to national health capital constraints;
ii. notes that the joint MoH/CDHB DBC Option 1b for Campus Masterplan Tranche 1 Implementation requiring $387m of Crown funds and $51m of CDHB funds – totalling $438m previously approved by the Board and Clinical Leaders Group (*CLG*) has been declined due to national health capital funding constraints;
iii. notes the Campus Masterplan Tranche 1 Reduced Cost Options A – E developed in conjunction with Reduced Cost Compliance Options appendix 1;
iv. approves the clearly preferred Campus Masterplan Tranche 1 Reduced Cost Option E ($218m) in conjunction with Lowest Anticipated Compliance Cost Option ($24m) requiring **$242m of Crown funds** and $51m of CDHB funds – totalling $**293m** of joint investment;

v. notes that the preferred option E includes six wards that are fitted out, a ward layout that is consistent with the Masterplan and does not compromise the ability to bring to life the remainder of the Christchurch Hospital Masterplan;

vi. notes that if the preferred Campus Masterplan Tranche 1 Reduced Cost Option E is not approved the CDHB preference order of the remaining options is as follows:

- Campus Masterplan Tranche 1 Reduced Cost Option D ($198m) in conjunction with Lowest Anticipated Compliance Cost Option ($24m) requiring **$222m of Crown funds** and $51m of CDHB funds – totalling **$273m** of joint investment; then
- Campus Masterplan Tranche 1 Reduced Cost Option C ($178m) in conjunction with Lowest Anticipated Compliance Cost Option ($24m) requiring **$202m of Crown funds** and $51m of CDHB funds – totalling **$253m** of joint investment; then
- Campus Masterplan Tranche 1 Reduced Cost Option B ($178m) in conjunction with Lowest Anticipated Compliance Cost Option ($24m) requiring **$202m of Crown funds** and $51m of CDHB funds – totalling $**253m** of joint investment; then
- Campus Masterplan Tranche 1 Reduced Cost Option A ($154m) in conjunction with Lowest Anticipated Compliance Cost Option ($24m)requiring **$178m of Crown funds** and $51m of CDHB funds – totalling **$229m** of joint investment; and

vii. approves the submission of the selected Reduced Cost Option to the MoH / CIC.

3. BACKGROUND

The 2012 Government approved, CDHB Facilities Redevelopment (Hagley) DBC stated further future projects were required on the campus and that they needed to be delivered by 2022 to keep pace with growing demand. The current DBC programme sees T3 completion in 2025, some three years later than required, incurring additional cost escalation and capacity concerns. It is also worth noting that the population projection in 2012 for 2020 has in reality been exceeded by 60,000 (a population expansion that places the region currently at levels not anticipated until 2024).

During the drafting of the jointly sponsored (MoH and CDHB) 2019 DBC/PBC document; the agreed goal was to complete a series of enabling works to the existing campus to facilitate the construction of T3 and Central Building and Tower 4 *(CT4)*; with both design and construction to be considered under one funding package; a process that would allow the removal of possible roadblocks to unlock the campus and assist the CDHB in delivering the necessary bed and theatre capacity as demand increases. The developed Option 1 achieved all of these criteria and was costed at $828m.

MoH indicated at the time that in order to align with the national capital funding envelope it would not be possible to undertake all these elements of work under a single tranche and the DBC was updated to deliver several separately funded tranches within a wider Programme Business Case.

In addition, the CDHB entered into a process with the MoH consultant team to significantly reduce the quantum of heavy / moderate refurbishments within the existing facilities following the philosophy that with limited capital available, as much of that capital as possible should be directed toward the new facilities rather than investing too much in existing facilities with limited future working life.

The result was the creation of DBC preferred Option 1b delivering a reduced existing facilities enabling work package, T3 design and construction and full design of CT4 (Tranche 1) and required $387m of Crown funds and $51m of CDHB funds – totalling $438m.

From CDHB's perspective, the compromises were contingent on agreement for a fast track programme to achieve CT4 (the construction of which had been moved to Tranche 2 although design was retained in Tranche 1 to keep the programme moving forward). Clinical leaders involved in this process had agreed, for example, in a reduction in scope for the Parkside works and redevelopment alone from circa

$150m down to $77m on the basis that the limited capital available should be focussed more prudently on new facilities.

The demand forecasting (both beds and theatres) has been through five separate external reviews between MoH/CDHB and expert consultants and is now agreed as per the DBC.

The MoH response to the submission of the jointly sponsored DBC has required the DHB to examine what might be achieved with a further reduced option. This process has significantly increased operational compromises as compared to DBC Option 1b as well as raising potential hurdles for future Campus development over and above what the CDHB had previously agreed to.

The reduced scope versions have retained critical elements that are essential to 'unlock' the site and are consistent with the overall agreed campus masterplan objectives, however, a number of these changes are making the implementation of the masterplan more difficult and expensive for the future. During the development of the reduced cost options, items such as passive fire and some elements of seismic work were excluded.

The result of this exercise was the development of Reduced Cost Options A to E. These all share a common baseline of items excluded from the DBC Option 1b and are described in each of the option sheets and associated financial spreadsheets following, but at a high level these include:

- Deleting all preparatory work for and around CT4.
- Removing work associated with offices and café in Hagley building.
- Leaving the existing Food Services building in service (blocking the way for CT4).
- Reducing the D space on Tower 3 (D space is shared clinical, rehabilitation and clerical facilities between two wards rather than replicating for each ward individually).
- Removal of some DBC allowances for seismic strengthening and all of the passive fire compliance (to be funded via an alternative source).

Initial discussions were held with the MoH Capital Team and the Reduced Cost options were well received. To enable the MoH to have a full picture on capital required it was requested that the CDHB produce further Options that cover passive fire and seismic repairs for the main Campus (excludes the St Asaph Street sites).

Two options were developed for the compliance work package, with the first being the scope of work as suggested by CDHB design consultants who have been developing various designs since 2011 earthquake and the second was a more aggressive view of what the lowest level of complying works may be. The CDHB has adopted the more aggressive approach and that has been included as the basis of the recommended costings.

The programme of works for this compliance package must fit around the Tower 3 programme and enabling packages in general terms, however, this is currently being pressured by the delay in the occupation of the Hagley building. Items such as the Women's passive fire rectification is independent but should also proceed within these timeframes.

Compliance work in relation to Parkside shear wall remediation will also result in the loss of another 24 beds and this has not been modelled into the MoH forecasting or the figures in this report for consistency. In addition, the Parkside shear tower work in blocks C and D will have operational impacts on operating theatres and Cath labs in that part of the building. Budgets in this paper refer to capital costs of doing the physical works but not the operational costs associated potentially with outsourcing of these clinical services.

Another key consideration is the step in T3 building height from five to six ward levels. The additional level provides another 32 beds (or potential for them once fitted out depending on the Option selected) in the immediate years, plus the future benefit of pairing up with a similar ward in CT4 providing clinical operating efficiency gains and horizontal fire egress. This proposed level would also provide a long term planning gain for the tight landlocked Campus and following projects for a minimal cost premium.

All of the Reduced Cost Options see the bulk of the existing facilities in Parkside retained for the next 10 to 15 years without any upgrades. This includes a large portion of the hospital's theatre capacity and these are generally the original theatres now in excess of 35 years old and have not had any significant upgrades in their life.

Please also note that given the current COVID-19 pandemic that none of the compliance work as outlined provides for a facility able to manage and cohort infected patients – this is an issue that the Board will need to provide some guidance on as to deal with this would take us back down the path of an accelerated CT4.

It must be emphasised that for each scale back in project capital cost there is a diminished return to the CDHB in terms of bed capacity and future gains (achieving the Master Plan outcomes).