DEPARTMENT OF THE PRIME MINISTER AND CABINET
TE TARI O TE PIRIMIA ME TE KOMITI MATUA

Proactive Release

The following documents have been proactively released by the Department of the Prime Minister and Cabinet (DPMC), on behalf of Hon Andrew Little, Minister of Health:

Health and Disability System Reform Briefings October 2021 to January 2022

The following documents have been included in this release:

Title of paper: Health Reforms: Realising the Digital Shift for the Health System

Title of paper: Development of the Interim Government Policy Statement for the Reformed Health and Disability System

Title of paper: Further advice on the Interim Government Policy Statement - Priorities for Inclusion

Title of paper: Health Reform: Choices to Expand the Public Offer

Title of paper: Health Reforms: Public Health Transformation

Title of paper: Health Reforms: Addressing Workforce Supply and Demand

Title of paper: Localities: Setting a Narrative, and Updating on Rollout and Prototypes

Title of paper: Further Advice on the Interim Government Policy Statement – High Level Approach to Priorities

Title of paper: Monitoring Arrangements for the New Health System

Title of paper: Restructure of Vote Health Appropriations to Support Health Reforms

Title of paper: Health Reform – Progress Update and Assurance Framework

Title of paper: Update on the Pae Ora Bill: Select Committee Progress and Further Policy Decisions

Title of paper: Pae Ora Bill: Key Policy Decisions for Recommendation in the Departmental Report

Title of paper: Allocation of Commissioning Budgets Across Future Health Entities

Title of paper: Health Reform: Transfer of Functions from Ministry of Health to New Entities

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DEPARTMENT OF THE PRIME MINISTER AND CABINET
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Briefing

UPDATE ON THE PAE ORA BILL: SELECT COMMITTEE PROGRESS AND FURTHER POLICY DECISIONS

To: Hon Andrew Little, Minister of Health			
Date	10/12/2021	**Priority**	Medium
Deadline	At your convenience	**Briefing Number**	DPMC-2021/22-1065

Purpose

This briefing provides you with an update on the Pae Ora (Healthy Futures) Bill, including a summary of key themes emerging from submissions, and advice on policy issues ahead of seeking your and Cabinet's agreement of potential changes to include in the departmental report. It also notes an outline of likely technical changes required for the Bill.

Recommendations

a. **Discuss** with your colleagues options for considering a Cabinet paper on policy decisions for the Pae Ora Bill early next year, enabling the Transition Unit to meet the Pae Ora Legislation Committee's timeframe for the departmental report

b. **Note** we have received 2,184 submissions from the Committee as of noon on Friday 10 December, with submissions from the final day not yet forwarded to us.

c. **Note** that we are awaiting direction on an explicit reference to rangatiratanga in the legislation, to follow your discussion with Mr Parker and Ms Allen. **Yes / No**

d. **Agree** to brief Cabinet on submitters' views about the broader approach to legislating for te Tiriti o Waitangi obligations in the Pae Ora Bill and your proposed approach to public communications on this issue

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e. **Note** that engagement led by the interim Māori Health Authority with prospective members of iwi-Māori partnership boards has confirmed the importance of the Pae Ora Bill specifying powers and functions for the boards

f. **Agree** to seek Cabinet approval for the functions and powers for iwi-Māori partnership boards, which are likely to reflect the list set out at paragraph 19, to be proposed for inclusion in the Pae Ora Bill via the departmental report to the Pae Ora Legislation Committee **Yes / No**

g. **Note** that officials are likely to propose an amendment to the Bill (via the departmental report) that would require Health NZ and the Māori Health Authority to consult established iwi-Maori partnership boards or relevant iwi and Māori organisations when determining 'localities' under the legislation

h. **Note** that officials are likely to propose additional minor amendments to iwi-Māori partnership board provisions in the departmental report to better meet the intention of the reforms, specifically requiring that:

- Iwi-Māori partnership boards are *engaged* (rather than consulted) in the preparation of locality plans;
- Health New Zealand and the Māori Health Authority have regard to the priorities and preferences expressed in locality plans when developing the New Zealand Health Plan; and
- decisions about the content of locality plans are within the scope of the dispute resolution process in the Bill.

i. **Agree** to seek Cabinet approval of the approach to ensuring the representativeness of iwi-Māori partnership boards, for inclusion in the Pae Ora Bill via the departmental report to the Pae Ora Legislation Committee. **Yes / No**

j. **Note** that submitters have expressed a desire to strengthen the accountability of the Māori Health Authority to Māori, and that officials can provide you with options to address this, if desired.

k. **Note** that officials will report to you in the New Year on the potential to require the Minister of Health to consult the Minister for Māori Development or the Hauora Maori Advisory Committee when considering disputes under the Pae Ora Bill.

l. **Note** that we have identified a number of minor and technical changes required to the Pae Ora Bill, which we will include the departmental report to the Pae Ora Legislation Committee.

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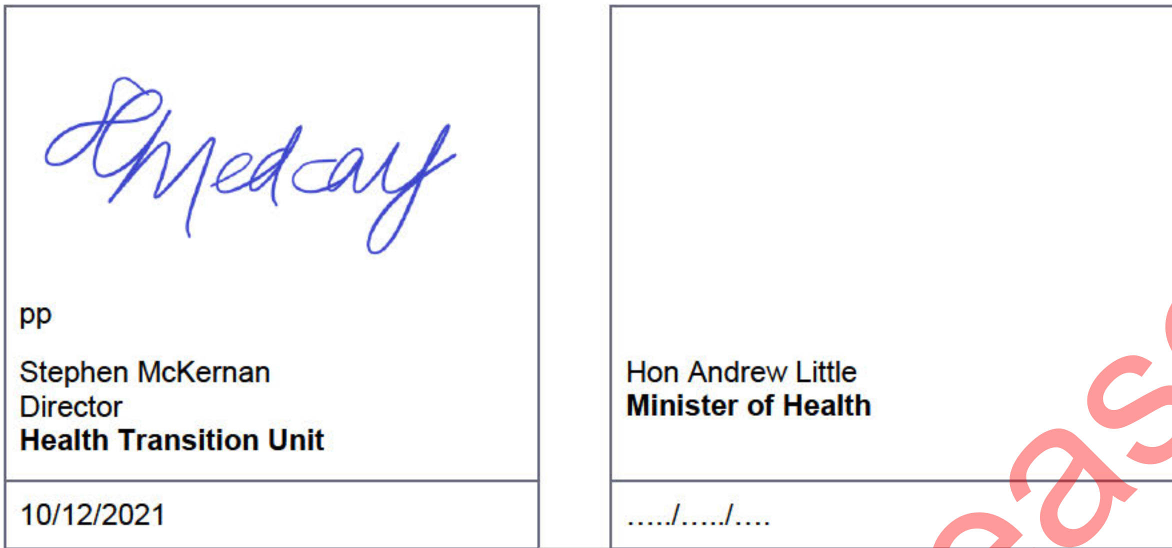

pp Stephen McKernan Director **Health Transition Unit**	Hon Andrew Little **Minister of Health**
10/12/2021	...../...../....

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UPDATE ON THE PAE ORA BILL: SELECT COMMITTEE PROGRESS AND FURTHER POLICY DECISIONS

Context

1. The Pae Ora (Healthy Futures) Bill is currently being considered by the Pae Ora Legislation Committee. Submissions closed on 9 December, and the Committee is expected to hear oral submissions early next year. The Committee is due to report back to Parliament on 27 April 2022, and have asked for the departmental report to be provided by 14 February.

2. There are a number of policy issues on which we will need to seek agreement before we can finalise the departmental report. Cabinet agreement will be required for proposed changes to the provisions relating to iwi-Māori partnership boards, and potentially in other areas, depending on submissions. We will therefore prepare a paper for Cabinet's consideration in early February, based on your steers and decisions. We also anticipate a meeting of the Ministerial Oversight Group in late January to discuss these issues and potential amendments to the Bill, in advance of Cabinet.

3. This briefing provides you with some early advice on anticipated issues to prepare you for decisions required in the New Year. It also notes some minor changes we expect to recommend in the departmental report to respond to submissions and better reflect the intent of the reform.

Key themes emerging from submissions

4. Submissions on the Bill closed on 9 December. As of noon on Friday 10 December, we have received 2,184 from the Committee clerks. We have not yet received the submissions from 9 December, but expect to receive them late on Friday 10 December, and can discuss them if necessary at our officials' meeting on Wednesday 15 December.

5. Only a small percentage of submitters raised substantive points. Many submissions were focused on 'separatism', expressing concern that the Bill would result in duplicate health systems, or that Māori would have privileged access to care unavailable to others. We will address these and other misconceptions in the departmental report.

6. Of the substantive submissions, most submitters who commented specifically have suggested strengthening provisions relating to the Māori Health Authority. In particular the National Hauora Coalition, one of the WAI 2575 claimants, has submitted that the Authority should be independent of the Crown.

7. Other submitters have made wide-ranging, but generally minor, suggestions for amendments; but submitters who were in favour of reform have generally been in agreement with the overall scheme of the Bill.

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8. We will provide you with further advice on submissions in the New Year. We anticipate a brief summary of themes will be available by the end of next week, should you wish to receive this.

Further policy issues

9. Agreement from you and/or Cabinet will be required on a number of key policy issues to be included in the departmental report. We expect to provide you with a draft Cabinet paper early next year to enable us to present the report to the Committee by 14 February.

10. The key policy issues for consideration relate to:

- the approach to Treaty provisions, including specific reference to rangatiratanga;
- iwi-Māori partnership boards;

  (the above would require Cabinet decisions)

- localities;
- accountability settings of the Māori Health Authority;

These issues are discussed in more detail under the headings below.

Approach to Treaty provisions

11. In September, Cabinet made a number of decisions about the approach to legislating for the Crown's Treaty obligations in the Bill [CAB-21-MIN-0378 refers]. As discussed in our recent briefing to you about giving effect to rangatiratanga [DPMC-2021/22-864 refers], the Crown has adopted a novel approach which seeks to respond to the strengths and weaknesses of previous approaches by providing both:

   a) a set of specific provisions that embed the balance of rangatiratanga and kāwanatanga in particular functions or processes (such as the role and functions of the Māori Health Authority), which are summarised in a descriptive clause that references the Crown's intention to give effect to Treaty principles; and

   b) a more comprehensive and flexible obligation on health entities to be guided by a set of health system principles, which aim to reflect key outcomes and behaviours contemplated by the WAI 2575 principles (as well as other recognised concepts of good health systems).

12. Concern with this approach has been raised by submitters, iwi representatives in most of the recent engagement hui led by the interim Māori Health Authority, and by the interim Māori Health Authority board itself. Several submissions do not appear to have recognised the combined effect of the two different components, and we expect the novelty of this approach and the ongoing debate around Treaty clauses more generally to result in some negative feedback from Māori.

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13. This is likely to be exacerbated by the fact that the Crown has proposed an 'operative' Treaty clause in the Natural and Built Environments Bill[1], and a number of recent high profile Supreme Court decisions that demonstrate the Courts' willingness to interpret legislation in the context of the Treaty. These factors strengthen the view that operative clauses facilitate faster progress in the Māori-Crown relationship by exposing it to greater intervention by the Courts.

Options

14. As briefed, we consider that an explicit, contextual reference to the relationship between rangatiratanga and kāwanatanga could be included in the descriptive clause. This would assist in addressing some of the concerns about the perceived weakness of the approach to Treaty obligations in the Bill. We await your direction on this point. Beyond this, changes to the approach would be more complex, and would create significant uncertainty for decision-making across the system.

15. Adding an operative Treaty clause in addition to the current approach would fundamentally change Cabinet's previous decisions, and would create significant confusion and interpretive risk for the legislation. Health entities would effectively be required to weigh and consider the impact of competing sets of principles: the Treaty principles and the health system principles (which already aim to reflect desired outcomes and behaviours consistent with the Treaty principles in a health context). At high legal weightings (such as 'give effect to') an operative clause would also increase the likelihood of the Court substituting its own decision for that of Health New Zealand or the Māori Health Authority on specific choices about service design or delivery.

16. For this reason, we do not recommend a change to the approach at this time. Engagement and submissions reveal some confusion about the new approach to the Treaty in legislation. A key part of the solution to this may include clearer public communications about this specific issue. We suggest you brief Cabinet on this point in February, highlighting that:

   - approaches to Treaty provisions should not be one-size-fits-all, but reflect the particular context. In the Pae Ora Bill, the Crown has sought to take a very practical and clear approach to Treaty obligations by providing for the Māori voice at all levels of the system;
   - it is the combined effect of specific provisions (such as the role of the Māori Health Authority) and the health system principles that provide for the Crown's Treaty obligations; and
   - the system principles aim to reflect the outcomes and behaviours that the Treaty principles would require in the health context and, like an operative clause, decisions by health entities can be judicially reviewed against these principles.

17. You could also put forward a specific communications approach to these issues in the Cabinet paper.

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[1] Clause 6 of the exposure draft provides that "All persons exercising and performing functions and duties under this Act must give effect to the principles of te Tiriti o Waitangi".

Iwi-Māori partnership boards

18. Since introduction, we have undertaken further analysis of the iwi-Māori partnership board (IMPB) provisions in the Bill, and have been supporting the interim Māori Health Authority in their engagement with Māori.

Powers and functions

19. In your submission to Cabinet Business Committee on 20 September 2021 [CAB-21-MIN-0378 refers] you highlighted an expectation that the Pae Ora Bill would need to specifically provide for IMPBs to perform the following functions:

    a) engaging with whānau and hapū about local health needs, and sharing the resulting insights and perspectives with Health New Zealand, the Māori Health Authority, and others;

    b) assessing and evaluating the current state of hauora Māori in their locality or localities, and determining priorities for improving hauora Māori;

    c) agreeing local priorities and locality plans with Health New Zealand and the Māori Health Authority;

    d) monitoring the performance of the health system in their localities, including against the locality plan;

    e) engaging with the Māori Health Authority to support its stewardship of hauora Māori and its priorities for kaupapa Māori investment and innovation; and

    f) reporting on their activities to whānau and hapori Māori, and other relevant partners.

20. At Cabinet's request, the interim Māori Health Authority has been engaging with iwi/hapū and associated entities (affiliated providers and commissioning agencies) to test these functions. We understand that the interim Māori Health Authority will be providing you with advice on IMPB functions, structures and powers directly in the New Year.

21. However, at the least, this engagement has confirmed the depth of interest in IMPBs playing a more meaningful role in the system, and we consider providing for the above functions in the Bill will be critical to securing overall iwi/Māori support for the reforms. As per the Cabinet minute, specific Cabinet approval of these functions early in the New Year will be required before they can be included in the departmental report.

Associated amendments to locality provisions

22. At the same time, these discussions have highlighted a desire by prospective IMPB members to be closely involved in determining the scale and geographical coverage of localities. The size and shape of localities will impact IMPBs and their ability to effectively feed into locality planning processes and adequately understand and represent Māori views and aspirations within their area.

23. We therefore consider it appropriate for IMPBs to have an influence on these choices, but are mindful that there are both local and national interests involved (in terms of effectiveness and efficiency). We are also conscious that localities and IMPB areas will be determined simultaneously but at different speeds across the initial two-year period post-enactment. The Bill does not provide a clear link between these processes at present.

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24. Taking this into account, we recommend that the Bill provide for Health New Zealand and the Māori Health Authority to consult both established IMPBs and relevant Māori organisations[2] when determining localities.

25. In addition, engagement has demonstrated a case for some minor, associated changes to the Bill to better meet the intention of the reforms, which we intend to progress through the departmental report. These include amendments to ensure that:

    a) IMPBs are *engaged* (rather than consulted) in the preparation of locality plans (to enable a genuinely collaborate process for determining local priorities and preferences);

    b) Health New Zealand and the Māori Health Authority have regard to the priorities and preferences expressed in locality plans when drafting the New Zealand Health Plan (and therefore in national and regional commissioning); and

    c) decisions about the content of locality plans are within the scope of the dispute resolution process in the Bill (albeit driven by an expectation of consensus in the first instance).

Constitution and representation issues

26. We have also identified some issues with the current Bill provisions relating to the constitution of IMPBs. Further engagement and analysis has highlighted the importance of IMPBs being fully representative of the Māori community in their proposed areas, and the challenges that some prospective boards may have in achieving this as they refresh, or move away from, existing DHB-oriented structures.

27. These challenges were also noted by the Minister for Māori Development in his letter to you of 8 October 2021, where he emphasised that the Crown must ensure urban Māori authorities and mātāwaka are adequately represented by IMPBs. Challenges in agreeing representation in areas with complex or highly disaggregated iwi and hapū structures have also been raised by Willow-Jean Prime MP in a Committee session, and these issues may feed into concerns about IMPB proposals more generally.

28. The current Bill provisions will 'deem' existing Māori Relationship Boards to be IMPBs via a schedule, thereby providing them with IMPB functions and powers at enactment. While the Bill also contains criteria aimed at achieving sufficient representativeness for future variations of or new IMPBs, this approach effectively assumes that those existing organisations are already or will be representative prior to the Bill coming into force.

29. Several prospective boards are making good progress on establishment plans, which could set out how they have addressed the representation question, with mana whenua from existing structures driving plan development. However, some are yet to specifically engage the wider Māori community, and others have signalled a reluctance to do so. At this stage, it is possible a number of prospective Boards will

[2] 'Relevant Māori organisations' are defined for the purpose of Māori Health Authority engagement with Māori as 'Māori organisations that the Māori Health Authority considers relevant for the purpose of the engagement (clause 20 of the Pae Ora (Healthy Futures) Bill.

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not have been able to meaningfully engage and resolve representation issues in time for them to be deemed IMPBs in the legislation.[3]

30. In addition, although the establishment of IMPBs should and will be Māori-led, the Crown is obliged to actively protect the interests of all Māori who may wish to be represented, including parties that iwi/hapū entities or existing IMPBs may not wish to include. Given the similarity with questions of mandate and overlapping interests in the historical settlement context, and the need for the Crown to protect the interests of more vulnerable or poorly-resourced parties, there is a strong argument for a clear and transparent statutory process for recognising all IMPBs post-enactment. 'Deeming' some (but not others) prior to enactment may suggest a double standard of transparency or protection.

An alternative statutory process for IMPB recognition

31. To address the issues set out above, we suggest an alternative process to recognise IMPBs. This could be an adapted version of the process currently set out in the Bill for the variations of IMPBs, with the Māori Health Authority assessing all establishment proposals after 1 July 2022 against more fulsome, but flexible statutory principles. These principles could include:

   a) **representativeness**, including:

      i) the sufficiency of engagement undertaken with the wider Māori community on the proposed structure; and

      ii) how well the membership or structure of the board reflects the way the Māori population in the IMPB area prefers to engage with the health system; or

      iii) whether the board has systems and processes in place to ensure it can represent the views of all relevant parties; and

   b) **the appropriateness of the area** proposed for IMPB coverage, including:

      i) the need for mutual exclusivity of IMPB areas to simplify locality planning;

      ii) the need for IMPB areas to be of a size that allows for efficient service planning; and

      iii) whether the area proposed would best allow the IMPB to achieve its functions (a broad principle like this is likely to be important in supporting the representation of iwi/hapū where rohe might straddle the boundaries of multiple IMPB areas).

32. Engagement with iwi and discussions with the interim Māori Health Authority have demonstrated the need for flexibility and discretion to meet local circumstances and minimise drawn out legal challenges to Māori Health Authority decisions to recognise IMPBs. We would look to balance this with the need for a clear signal in the principles of what is expected of prospective boards.

[3] Ideally, the Crown would need a high level of confidence in the representativeness of proposed IMPB structures by early February in order to make recommendations about the content of the Schedule in the departmental report. Even then, the deeming of some boards but not others would be l kely to attract significant debate within the Committee.

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33. The principles would also need to promote the idea that boards can mix 'literal' representation with systems or processes that allow them to understand and represent the views of particular groups or parts of the Māori community (to ensure the boards do not become unwieldy and minimise conflict of interest risk for Māori providers).

34. This approach would not prevent the interim Māori Health Authority from working constructively with the 'front-running' prospective boards to accelerate their establishment plans (many of the boards may still be ready to submit their plans soon after 1 July 2022). Neither would it prevent prospective IMPB parties from participating in the locality prototyping process early next year, as this would not depend on legal status for IMPBs in the short term, and the Crown can be inclusive in who it invites to participate in such processes.

Next steps and communication

35. We are making good progress on revised drafting instructions for these clauses with input from Te Arawhiti, Te Puni Kōkiri, and the Crown Law Office. However, given the finely balanced nature of the principles and the need to ensure that uncertainty on these issues does not cloud decisions on the powers and functions question, we recommend you also seek specific Cabinet approval of this approach before we propose amendments in the departmental report.

36. Any such amendments are likely to be the focus of debate at Committee in April, but, as they would not be made public until the Bill is reported back to the House at the end of that month, there will be a need for the Crown to communicate clearly about these provisions at that time. If asked about these issues by the Committee prior to the departmental report, we propose to acknowledge the specific issues with the current provisions without pre-empting Cabinet decisions on a particular solution.

37. At the same time, the Māori Health Authority board is signalling the importance of these points in its current engagement with iwi and hapū.

Localities

38. Localities have been a key issue of interest emerging out of our engagement with the health sector and Māori, and was the topic of several questions from Committee members at the initial briefing. You recently received advice setting out an agreed narrative on how we explain localities [DPMC-2021/22-931 refers].

39. In summary, we will outline and explain localities through a focus on the experiences of people, localities as a community-based, geographic concept, and will set expectations for what localities will look like over time.

40. We will use this agreed narrative to inform the departmental report, as well as responses to questions about localities in the context of the wider work of the Transition Unit. We do not consider any changes to the current locality provisions in the Bill are required to achieve the vision for localities, however updates will be necessary to reflect the suggested changes to the iwi-Māori partnership board provisions, as discussed above if agreed.

Accountability settings of the Māori Health Authority

41. Virtually all submitters that commented on the detail of the Māori Health Authority expressed a desire to see the independence of the Authority and its accountability to

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Māori strengthened. In September, Cabinet made specific decisions about the institutional accountability of the Māori Health Authority [CAB-21-MIN-0378 refers], including how to reflect its dual accountability to Parliament and Māori. While applying most of the relevant provisions of the Crown Entities Act 2004, Cabinet aimed to provide for accountability to Māori by requiring:

a) the Māori Health Authority to engage with Māori in performing its functions;

b) the Minister of Health to:

   i. *consult* the Hauora Māori Advisory Committee on specific board appointments and removals, or when issuing directions; and

   ii. *obtain the agreement* of the Hauora Māori Advisory Committee when replacing the board with a Commissioner or appointing a Crown observer.

42. Some submissions have questioned whether it is appropriate for the Crown to retain the determinative role in appointments to the Māori Health Authority board, and how well the Hauora Māori Advisory Committee represents Māori for the purpose of the Treaty relationship. Some of these submissions put forward the specific proposals raised with you by the Steering Group earlier this year, including:

a) the idea that the role of the Hauora Māori Advisory Committee could be exercised by a broader 'taumata' of Māori; or

b) that board appointments could be made (at least partly) via an arrangement similar to that used for Te Mātāwai, where rights to appoint board members are apportioned to iwi 'selection' clusters and Māori interest groups around the country[4].

43. These options were also raised by the Minister for Māori Development in his October letter to you. Broadly speaking, we consider that a permanent taumata (exercising the functions of the Advisory Committee as currently designed) is unlikely to improve accountability to Māori, while presenting risks to the efficiency and timeliness of the governance functions exercised in this context.

44. However, should you wish to provide for more direct representation for Māori in these processes, we consider that a version of the Te Mātāwai process could be designed to work for either appointments to the board of the Māori Health Authority or the Hauora Māori Advisory Committee. Alternatively, the current institutions could remain, but the role of the Hauora Māori Advisory Committee could be strengthened (for example, requiring agreement of the Committee for individual board appointments).

45. We will report further to you on this issue if submissions from Māori highlight a strong preference for change in this area.

Dispute resolution processes

46. Additionally, submissions have raised concerns with the dispute resolution process where Health New Zealand and the Māori Health Authority cannot agree on a matter they are required to work together on. Current drafting provides that if their chief executives are unable to resolve the dispute between themselves, a dispute must be

[4] For Te Mātāwai, the responsible Minister still appoints two of the 13 members, and can appoint other members if the iwi selection approach fails to produce an appointment for any of the seats. The selection groups must consider the need for Te Mātāwai to have a membership with the appropriate mix of knowledge, skills, and experience relative to its functions.

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referred to the Minister of Health. The Minister may determine the dispute or a process to resolve the dispute, the outcome of which the parties must comply with. Some submitters have challenged the appropriateness of the Crown making such decisions unilaterally.

47. Options to respond to this issue could include an additional requirement for the Minister of Health to consult either the Minister for Māori Development or the Hauora Maori Advisory Committee when considering a dispute. In either case, we would not recommend that agreement be sought, or this could replicate the same stasis that the provisions are intended to resolve. However, a requirement to consult could provide some level of check on the Minister's powers and allay some concerns on how these might be applied. This change could be included in the departmental report, and we will make more specific recommendations to you next year following further analysis of submissions.

Transition arrangements for chief executives of departmental agencies

48. It is likely we will propose changes to the transitional and consequential provisions. While most will be minor and technical, we intend to propose an amendment to the transition provisions that will transfer employees of the interim agencies to the permanent agencies. This will be similar to the current provision transferring DHB employees.

49. As discussed with you in our meeting on 8 December, we propose that this provision explicitly include the chief executives of the two interim agencies, so that these individuals become the chief executives of the permanent agencies on Day 1. This would support the policy intent which has been to appoint to these roles on the basis that the individuals would become the permanent chief executives in due course. Although it would remove the ability of the permanent boards of the entities to make these appointments formally after 1 July 2022, it would provide certainty to the individuals and to the wider system on its future leadership. This approach is also supported by the chair of the interim Health NZ Board.

50. Although there may be a case for similarly applying these provisions to transfer the boards of the interim agencies (i.e. the Section 11 advisory committees) to become the boards of the permanent agencies, we do not recommend this step also be taken at this time. This may give the impression of confirming governance arrangements without due process, in particular given the expected role of the Hauora Māori Advisory Committee in supporting such appointments. We can provide fuller advice on this, should you wish.

Additional changes to the Bill

51. We have identified a number of minor changes required to the Bill to ensure it reflects and achieves the policy intent, and to correct some typographic and syntax errors. While these are minor and we will not seek individual agreement they will be included in the departmental report which you will have the opportunity to review.

52. These changes include:

- removing incorrect references to the Cancer Control Agency;

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- updating the transitional provisions to ensure that employees transferring between agencies retain their existing terms and conditions;
- better aligning the descriptions of the functions of health entities; and
- reframing the Code of Consumer Participation to focus on expectations for engaging consumers, rather than principles, after discussion with the Health and Quality Safety Commission.

Next steps

53. We will continue to analyse submissions and support the Pae Ora Legislation Committee as needed. As referenced above, we have begun to develop the departmental report as Committee timeframes are tight. To ensure we can present the report in mid-February, we will need to obtain agreement from you and Cabinet on the key issues highlighted in this briefing.

54. To meet this timetable, we expect the next steps will be:

- Draft Cabinet paper/supporting advice to Minister – 21 January (depending on availability). The covering advice will seek decisions on any aspects for you alone to decide; otherwise the Cabinet paper will seek necessary decisions.
- Ministerial Oversight Group meeting to discuss proposed amendments – in week of 24 January
- Consultation on Cabinet paper following Ministerial Oversight Group meeting – potentially from later in the week of 24 January
- Lodge Cabinet paper – 3 February
- Cabinet/CBC – week of 7 February
- Final departmental report to Minister for information – 11 February
- Send departmental report to Committee – 14 February

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