Health New Zealand
Te Whatu Ora

8 July 2024

s 9(2)(a)

Tēnā koe s 9(2)(a)

Your request for official information, reference: HNZ00047448

Thank you for your email on 10 May 2024, asking Health New Zealand | Te Whatu Ora for the following under the Official Information Act 1982 (the Act):

> *"Under the Official Information Act 1982 I request copies of the briefings to the Minister of Health listed below:*
>
> - *HNZ00038574 9(2)(f)(iv) 1/03/2024*
> - *HNZ00039139 Aide Memoire - Information on Community Pharmacy 7/03/2024*
> - *HNZ00039029 Aide Memoire: PHO Funding 8/03/2024*
> - *HNZ00039526 Aide Memoire - Critical Care beds 13/03/2024*
> - *HNZ00039572 Aide Memoire - Cybersecurity Update 14/03/2024*
> - *HNZ00038631 Aide Memoire - Q2 Performance Report 15/03/2024*
> - *HNZ00039805 Aide Memoire - Commissioning Pacific Provider Services 15/03/2024*
> - *HNZ00040417 Meeting Briefing - Central Lakes Proposal 18/03/2024*
> - *HNZ00032347 Briefing - Mason Clinic Request for Additional HCE Funding for Immediate Cost Pressures 18/03/2024*
> - *HNZ00038905 Meeting Briefing - Hira Programme Update 19/03/2024*
> - *HNZ00040218 Aide Memoire - Cleanliness of Hospitals 20/03/2024*
> - *HNZ00041624 Briefing - 23/24 Revised Budget Target and Financial Pressures 21/03/2024*
> - *HNZ00039093 Aide Memoire - Follow up to your 19 February meeting with GenPro 22/03/2024*
> - *HNZ00040306 Aide Memoire - Response to OAG Audit of HNZ for the Year Ended 30 June 2023 22/03/2024*
> - *HNZ00041107 Event Briefing - Connect 24 22/03/2024*
> - *HNZ00041342 Aide Memoire - HWIP December 2023 Workforce Data 22/03/2024*
> - *HNZ00041829 9(2)(f)(iv) 23/03/2024*
> - *HNZ00041210 Briefing - B22 Data and Digital Foundations and Innovation Contingency Extensions Required 25/03/2024*
> - *HNZ00041204 Aide Memoire - Hospital and Specialist Services - Hotspots 25/03/2024*
> - *HNZ00039244 Aide Memoire - Winter Plan Review 27/03/2024*
> - *HNZ00040256 Aide Memoire - Māori Health Pipeline: An Evidenced Based Approach to Reducing the Life Expectancy Gap for Māori 27/03/2024*
> - *HNZ00034260 Briefing - Copper Pipes Tranche Two (10255) 27/03/2024*
> - *HNZ00032350 Joint Briefing - Seeking Approval for Budget Uplift for Infrastructure Projects from Baseline Depreciation Cash 27/03/2024*
> - *HNZ00041914 Event Briefing -Flu Immunisation Launch Event 27/03/2024*
> - *HNZ00038968 Aide Memoire - Update on Health Capital Projects as at 31 January 2024 28/03/2024"*

Response

We are withholding the following documents in full under the grounds identified in the table below:

Title	OIA Grounds
HNZ00038574 Title Withheld 1 March 2024	Withhold in full under section 9(2)(f)(iv) to maintain the constitutional conventions that protect the confidentiality of advice tendered by Ministers and officials.
HNZ00039572 Aide Mémoire - Cybersecurity Update 14 March 2024	Withhold in full under section 9(2)(c) to avoid prejudice to measures to protect the health or safety of the public.
HNZ00039805 Aide Mémoire - Commissioning Pacific Provider Services 15 March 2024	Withhold in full under section 9(2)(f)(iv)
HNZ00041624 Briefing - 23/24 Revised Budget Target and Financial Pressures 21 March 2024	Withhold in full under section 9(2)(f)(iv)
HNZ00041829 Title Withheld 23 March 2024	Withhold in full under section 9(2)(f)(iv)

We are releasing the documents listed below to you subject to information being withheld under the sections identified in the table. These are attached as **Appendix 1**.

No.	Reference	Date	Title	OIA Grounds
1.	HNZ00039139	7 March 2024	Aide Mémoire - Information on Community Pharmacy	Information withheld under section 9(2)(a) to protect the privacy of natural persons, including deceased natural persons.
2.	HNZ00039029	8 March 2024	Aide Mémoire: PHO Funding	Information withheld under section 9(2)(a)
3.	HNZ00039526	13 March 2024	Aide Mémoire - Critical Care beds	Information withheld under section 9(2)(a)
4.	HNZ00040417	18 March 2024	Meeting Briefing - Central Lakes Proposal	Information withheld under section 9(2)(a)
5.	HNZ00038905	19 March 2024	Meeting Briefing - Hira Programme Update	Information withheld under sections: • 9(2)(a), • 9(2)(f)(iv) and • 6(a) as its release would likely prejudice the international relations of the Government of New Zealand.
6.	HNZ00040218	20 March 2024	Aide Mémoire - Cleanliness of Hospitals	Information withheld under section 9(2)(a)
7.	HNZ00041342	22 March 2024	Aide Mémoire - HWIP December 2023 Workforce Data	Information withheld under sections: • 9(2)(a) and

				• 9(2)(g)(i) to maintain the effective conduct of public affairs through the free and frank expression of opinions by or between or to Ministers and officers and employees of any public service agency.
8.	HNZ00039093	22 March 2024	Aide Mémoire - Follow up to your 19 February meeting with GenPro	Information withheld under sections: • 9(2)(a), • 9(2)(f)(iv) and • 9(2)(j) to enable a Minister or any public service agency to carry out commercial activities without prejudice or disadvantage.
9.	HNZ00040306	22 March 2024	Aide Mémoire - Response to OAG Audit of HNZ for the Year Ended 30 June 2023	Information withheld under section 9(2)(a)
10.	HNZ00041107	22 March 2024	Event Briefing - Connect 24	Information withheld under section 9(2)(a)
11.	HNZ00041204	25 March 2024	Aide Mémoire - Hospital and Specialist Services - Hotspots	Information withheld under section 9(2)(a)
12.	HNZ00039244	27 March 2024	Aide Mémoire - Winter Plan Review	Information withheld under section 9(2)(a)
13.	HNZ00041914	27 March 2024	Event Briefing -Flu Immunisation Launch Event	Information withheld under section 9(2)(a)
14.	HNZ00040256	27 March 2024	Aide Mémoire - Māori Health Pipeline: An Evidenced Based Approach to Reducing the Life Expectancy Gap for Māori	Information withheld under section 9(2)(a)

We are still processing your request for the documents listed in the table below. We will communicate a final decision on these as soon as practicable.

No.	Reference	Date	Title
1.	HNZ00038631	15 March 2024	Aide Mémoire - Q2 Performance Report
2.	HNZ00032347	18 March 2024	Briefing - Mason Clinic Request for Additional HCE Funding for Immediate Cost Pressures
3.	HNZ00041210	25 March 2024	Briefing - B22 Data and Digital Foundations and Innovation Contingency Extensions Required

4.	HNZ00032350	27 March 2024	Joint Briefing - Seeking Approval for Budget Uplift for Infrastructure Projects from Baseline Depreciation Cash
5.	HNZ00034260	27 March 2024	Briefing - Copper Pipes Tranche Two
6.	HNZ00038968	28 March 2024	Aide Mémoire - Update on Health Capital Projects as at 31 January

How to get in touch

If you have any questions, you can contact us at hnzOIA@tewhatuora.govt.nz.

If you are not happy with this response, you have the right to make a complaint to the Ombudsman. Information about how to do this is available at www.ombudsman.parliament.nz or by phoning 0800 802 602.

As this information may be of interest to other members of the public, Health NZ may proactively release a copy of this response on our website. All requester data, including your name and contact details, will be removed prior to release.

Nāku iti noa, nā

Danielle Coe
Manager (OIA) Government Services
Health New Zealand | Te Whatu Ora

Aide Mémoire

Information on Community Pharmacy

To:	Hon Dr Shane Reti, Minister of Health	Reference:	HNZ00039139
From:	Martin Hefford. Director, Living Well	Due Date:	7 March 2024
Copy to:	-	Security level:	In Confidence

Contact for telephone discussion (if required)			
Name	Position	Telephone	1st contact
Billy Allan	Principal Service Development Manager, Pharmacy Services, National Commissioning	S 9(2)(a)	x
Astuti Balram	Group Manager, Primary Care, Living Well, National Commissioning		
Martin Hefford	Director, Living Well, National Commissioning		

Purpose

1. This paper provides you with information regarding existing funding for community pharmacies and the IT preparedness of Health New Zealand | Te Whatu Ora (Health NZ) to support the reinstatement of the standard $5 prescription co-payment from 1 July 2024.

Background / context

2. Health NZ contracts directly with individual community pharmacies (currently about 1,041).
3. The fees and payments for community pharmacy services are described under the Integrated Community Pharmacy Services Agreement (ICPSA).
4. The ICPSA is an 'evergreen' contract with an annual review process, the National Annual Agreement Review (NAAR).
5. Each year the NAAR considers the nationally consistent parts and service schedules of the ICPSA, as well as any Schedule 3B Service Schedule[1] that the participants agree to consider as part of the review.
6. COVID-19 Care in the Community (COVID-19 vaccines and COVID-19 antiviral medicine supply) and rapid antigen test (RATs) distribution agreements sit outside of the ICPSA.

[1] The Schedule 3B services are services for which there is a national service specification, but which can be changed following the local Health NZ district commissioning process outlined in the ICPSA.

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New Zealand Government

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Community pharmacy funding streams

Health NZ spend and forecast expenditure against the ICPSA

7. The table below forecasts Health NZ's expenditure on community pharmacy services under the ICPSA. The forecast uses financial year 2022/23 (FY22/23) as its base year. Appendix 1 includes further details on payments. Most of the costs relate to dispensing of medicines. The forecasts assumptions are summarised in Appendix 2.

Service fee	FY22/23	FY23/24	FY24/25	FY25/26	FY26/27
Case Mix					
Case Mix Service Fee is paid for each patient visit (all dispensings to one patient on one day are a 'visit'). The calculation of the fee is based on the number and type of medicines dispensed.	$296.1m	$349.2m	$363.6m	$378.2m	$395.9m
Dispensing Fees					
Handling Fees The handling fee varies with the type of dispensing	$160.9m	$189.9m	$197.7m	$205.6m	$215.2m
Per Pack Fees A fee for each pack in the dispensing and a contribution towards the procurement and stockholding costs.	$14.0m	$16.5m	$17.2m	$17.9m	$18.7m
Drug Margins This is a contribution towards the procurement and stockholding costs to the pharmacy for the pharmaceutical.	$64.6m	$67.2m	$69.9m	$72.7m	$75.6m
Professional services					
Additional Professional Advisory Services Aims to recognise the professional advisory services each pharmacy provides.	$64.3m	$48.2m	$48.2m	$48.2m	$48.2m
Long-Term Conditions programme Payment for each patient enrolled in the LTC programme	$37.1m	$38.6m	$40.1m	$41.7m	$43.4m
Immunisation fees	$9.3m	$11.9m	$12.5m	$13.1m	$13.8m
Other expenditure	$11.3m	$9.9m	$9.4m	$8.1m	$7.3m
TOTAL	**$657.6m**	**$731.5m**	**$758.7m**	**$785.6m**	**$818.1m**
Increase over prior year		11.2%[2]	3.7%	3.6%	4.1%

2 See Appendix 3 for an explanation for the relatively large estimated percentage increase between F22/23 and F23/24 (11.2%).

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8. The reimbursement for the cost of medicines dispensed is not included above, as medicines cost reimbursement to pharmacies is paid by Pharmac from the combined pharmaceutical budget. Pharmac have advised that based on their 2022/23 annual report, the gross cost of the funded medicines and devices dispensed through community pharmacies, was $1.346 billion in 2021-22, and $1.432 billion in 2022-23.

9. Funding under the ICPSA is multifactorial and complex. However, growth in community pharmacy expenditure is largely driven by dispensing volumes (initial and repeat dispensings) and the Pharmaceutical Margin,[3] both of which are outside community pharmacy's control and direct influence.

10. Prescription volumes are determined by prescribers, their prescribing decisions, the number of patients they prescribe for, the number of medicines prescribed, and the cost of those medicines as determined by Pharmac through the Pharmaceutical Schedule.

11. Pharmac's funding decisions determine the subsidised cost of medicines which impacts pharmacy service fee lines, for example the Per Pack Fee and the Pharmaceutical Margin.

12. Global medicine supply shortages drive additional costs through increases in dispensing frequencies (initial and repeat dispensings) and increases in the management costs associated with the use of unapproved medicines.[4] At times, Pharmac must contract and subsidise an unapproved medicine when the New Zealand approved and Pharmac contracted medicine experiences a supply shortage.

Recent price uplifts

13. Price up-lifts over past years are summarised in the table below:

Year	Price uplift	Additional price uplifts
2023/24	5.0%	29.5% increase in the immunisation administration fee Addition of an influenza + shingles vaccine co-administration fee
2022/23	3.0%	31.1% increase in the immunisation administration fee
2021/22	2.78%	2.78% increase in the immunisation administration fee
2020/21	2.84%	3.51% increase in the immunisation administration fee

How pharmacies charge for pharmaceuticals

14. Funded medicines are managed by Pharmac. Pharmac lists funded medicines and devices in the Pharmaceutical Schedule. A product listing includes a reimbursement rate (the pharmaceutical subsidy) for each product.

15. Community pharmacies purchase medicines in advance of dispensing at their own cost. Medicines on a pharmacy's shelves are maintained at the pharmacy's cost and risk. For example, if a product goes out of date, or a part pack remains after dispensing, the pharmacy meets the cost of the loss of that product.

[3] The Pharmaceutical Margin is a payment towards the procurement and stockholding costs for a subsidised pack of a Pharmaceutical as listed in the Pharmaceutical Schedule

[4] Unapproved medicines are supplied under section 29 of the Medicines Act 1981. The Medicines Act imposes administrative and reporting requirements when unapproved medicines are used.

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16. An exception to pharmacies having to purchase medicines in advance is most funded vaccines which are obtained free of charge (as for general practice).
17. Under the ICPSA pharmacies are not permitted to add any mark-up to the cost of dispensed medicines (unless the Pharmaceutical Schedule permits a 'part-charge', or there is a prescription co-payment). Funded medicines must be free to patients.
18. Pharmacies are permitted to charge for ancillary services, for example compliance packaging.
19. Once dispensed, the pharmacy claims through their Pharmacy Management System, the cost of the medicine and the service fee(s), less any prescription co-payment collected on the government's behalf.

Community pharmacy retail activity

20. The extent of reliance on non-funded services is a business decision for each pharma y and is independent of government, Health NZ and the ICPSA.
21. Different models of care / business models exist. Health NZ does not hold any data on the split between government funded services and private non-funded activities undertaken by community pharmacies.

IT preparedness to support the reinstatement of the standard $5 prescription co-payment

22. You requested confirmation that Health NZ's IT processes are on track to enable the reinstatement of the standard $5 prescription co-payment from 1 July 2024, specifically:
    - the ability for pharmacists to look up Community Service Card information.
    - the ability for pharmacists to look up across families to consider prescription cost caps.
23. The IT enablers are on track to support the reinstatement of the standard $5 prescription co-payment
24. Community Services Card (CSC)
    - Health NZ is implementing an entitlements service that returns CSC data for a particular National Health Index (NHI) number. This will enable pharmacists to easily identify whether someone is a CSC holder and is exempt from the $5 prescription co-payment when integrated into their pharmacy management system (PhMS).
    - Health NZ will undertake further IT development to enable pharmacists to connect CSC cards to NHI numbers for the cases where data mismatch means that this cannot be done automatically, and to link dependents of a cardholder to a CSC.
    - These changes will be implemented for 1 July 2024.
25. Pharmaceutical Subsidy Card (PSC) – cap at 20 count of paid prescription co-payments
    - Health NZ is implementing similar changes to connect PSC to PhMSs.
    - These changes will be implemented in two phases:

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1. Phase 1: to be implemented by 1 July 2024
   - Implement 'look it up' where a patient's PSC status (not count of paid prescription co-payments) is displayed in the PhMS when the pharmacist enters a patient's NHI.
   - If a PSC has not been issued pharmacists will still need to look up the individual counts for each member of the PSC family unit.
2. Phase 2: to be implemented by 1 February 2025 (the start of the new 'pharmaceutical year' for the PSC)
   - Implement 'create the PSC' rather than the PSC status being crea ed in the claims process.
   - The entitlements service would offer an API web service showing the 'count of paid prescription co-payments' for an NHI
   - The pharmacy management software will use the 'c unt o paid prescription co-payments' API to count all NHIs in the family unit whe e the family NHIs are known in the PhMS.

Community Pharmacy Redesign

26. Health NZ has commenced a programme of system and service redesign for community and primary care. The programme will be scoped with the community pharmacy sector and is expected to review the current community pharmacy service delivery and funding model, with the view to developing futu e focused models. There are current innovative models e.g., the offering of afterhours a cess through a pharmacy, that are expected to be expanded on as well as the po ential to better use of the clinical skills of pharmacists, e.g., through supporting the pharmacy technician scope of practice. This work is anticipated to be completed by 1 July 2026.
27. We anticipate that this will result in a simpler p yment mechanism for pharmacy services.
28. While this wider redesign programme is developed, Health NZ has worked with the pharmacy sector to re nstate an Expert Advisory Group, linked to the NAAR, to progress service improvements to existing services. This will see improvements to services such as the Community Pharmacy Anticoagulant Management Services (CPAMS). There are also opportunities to have community pharmacists diagnosing and treating specific conditions such as Strep throat.

Next steps

29. Health NZ wil provide you with further information on the ICPSA and funding for community pharmacies if requested.
30. You will receive a briefing in May 2024 (or when the financial year 2024/25 budget is available) on the contract price uplift for 2024.

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Appendix 1

ICPSA funding service lines for community pharmacy

<table>
<tr><th colspan="3">ICPSA funding service lines (all values are GST exclusive)</th></tr>
<tr><td colspan="3">1. Dispensing
Payment for dispensing activity is made up of several components:
Dispensing Transaction Fee. The standard payment for each dispensing completed. The pharmacy receives all the following:</td></tr>
<tr><td></td><td>Pharmaceutical subsidy</td><td>Pharmacies purchase pharmaceuticals from pharmaceutical wholesalers. The medicines cost reimbursement to pharmacies is paid by Pharmac from the combined pharmaceutical budget</td></tr>
<tr><td></td><td>Margin</td><td>• If the cost of the pharmaceutical is less than $150 per pack: 3% of the pharmaceutical subsidy.
• If the cost of the pharmaceutical than $150 or more: 4% of the pharmaceutical subsidy
• This payment is a contribution towards the procurement and stockholding costs to the pharmacy for the pharmaceutical</td></tr>
<tr><td></td><td>Per Pack Fee</td><td>• A fee for each pack in the dispensing (if it's a part pack, then it's a part fee). The fee value is reviewed every quarter.
• This is also a contribution towards the procurement and stockholding costs for the pharmaceutical</td></tr>
<tr><td></td><td>Handling Fee</td><td>• Total Handling Fee = $1.01 x Handling Fee Multiplier
• The handling fee multiplier varies with the type of dispensing.
• For example:
– Aseptic services 26.50
– Sterile Manufacturing Services 26.50
– Clozapine services 10.60
– Extemporaneously Compounded Preparations 7.95</td></tr>
<tr><td colspan="3">2. Case mix service fee
• A single Case Mix Service Fee is paid for each patient visit (all dispensings to one patient on one day are called a 'visit'). The calculation of the fee is based on the number and type of medicines dispensed.
• Payments are made in three stages.
– an advanced fee – based on a pharmacy's dispensing activity in the previous period.
– an interim fee – based on actual dispensing activity for the month; where Health NZ may make additional payments or deduct an overpayment from the next case-mix payment.
– an end of year wash-up</td></tr>
<tr><td colspan="3">Initial dispensings
• A fee for each initial item dispensed.
– multiplied by 1.02 if there were four initial items that visit
– multiplied by 1.03 if there were five
– multiplied by 1.04 if there were six or more items.</td></tr>
</table>

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ICPSA funding service lines (all values are GST exclusive)

- This recognises the work required where the patient's situation is complex, such as ensuring drug interactions are check for and explained to the patient

Repeat item dispensings

- A fee for each repeat item dispensed
  - multiplied by 1 if the dispensing is the is 2nd or 3rd dispensing on from the same prescription,
  - multiplied by 0.60 if it is 4 to 12
  - multiplied by 0.40 if it is 13 to 28
  - multiplied by 0.35 if it is 29 or higher
- This recognises that the longer a patient has been on a medicine, the less support the patient requires

3. **Additional payment for dispensing unapproved medicines (also known as section 26/29 medicines)**

When Pharmac funds a medicine that is not approved by Medsafe, pharmacies receive a payment in recognition of the additional cost for the medicine and additional administration that is required for unapproved medicines.

Top-up margin	• If the cost of the pharmaceutical is less than $150 per pack: 7% of the pharmaceutical subsidy. • If the cost of the pharmaceutical is less than $150 or more per pack: 6% of the pharmaceutical subsidy
Additional margin payment	• A standard payment
Counselling payment	• A standard payment

4. **Brand-switch Fee**

- This fee recognises the additional support a pharmacy must provide to a patient when the funded brand of a medicine changes.
- Pharmac applies their Brand Switch Fee criteria when determining if a Brand Switch fee should be paid when the funded brand of a medicine changes.

5. **Additional Professional Advisory Services (APAS)**

- The APAS payment recognises the professional advisory services each pharmacy provides in addition to those undertaken in relation to dispensing.
- APAS is paid from a total Payment Pool, the amount of which is determined by NAAR each year.
- APAS payments are based on a pharmacy's 'equity profile'.
- Each pharmacy's allocation of the ASAP pool is determined by:
  - the number of unique visits by patients to the pharmacy for dispensing services
  - the number of dispensings per patient
  - patients' ethnicity (Māori or Pasifika)
  - High Use Health Card (HUHC) or Community Services Card (CSC) holder status

6. **Immunisation administration fee**

- Payment for the administration of a funded vaccine under the national immunisation schedule
- For some vaccines (eg, influenza) the pharmacy is also reimbursed the Pharmaceutical Schedule subsidy (where the vaccine has not been provided free of charge into the pharmacy)

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ICPSA funding service lines (all values are GST exclusive)	
7.	**Long-Term Conditions (LTC) programme (medicine adherence support)** • Payment for each patient enrolled in the LTC programme
8.	**Community Pharmacy Anticoagulant Management Services (CPAMS)** • Payment for each patient enrolled in CPAMS if that patient received at least one service (ie, an INR test) in that month
9.	**Smoking Cessation Services** • Payment for each patient enrolled in the smoking cessation programme with a pharmacy
10.	**Locally commissioned services** • Each Health NZ district may create further programmes and payments at their discretion and with the agreement of their ICPSA holders • Examples include contracting for opening outside of normal business hours, payments to support rural pharmacies; gout management; funded provision of emergency contraception

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Appendix 2

Assumptions underpinning the Health NZ spend and forecast expenditure against the ICPSA[5] (Table in paragraph 7 above)

1. The forecast uses financial year 2022/23 (FY22/23) as its base year, as this is the latest year for which expenditure data is complete. The forecast then uses a multiplier on the base year for each expenditure line and for each future year, out to FY26/27. The method of calculating each multiplier is specific to each expenditure line, and uses historic data, current and future events, and assumptions as to how those events will affect demand.
2. The forecast covers expenditure on pharmacy services covered by the ICPSA. It does not cover:
   - the costs of pharmaceuticals themselves (reimbursed by Pharmac from the Combined Pharmaceutical Budget)
   - payments outside of the ICPSA, including services fees for COVID-19 vaccinations, the supply of COVID-19 antiviral medicines
   - payments for partly funded medicines.
3. The forecast is conducted based on the current ICPSA agreement and does not make any assumptions about how future annual reviews might change the ICPSA or funding levels.
4. Assumptions in the forecast analysis include the impact of different actions on the service lines:
   - initial dispensing volumes (summarised in the table below):

Base	FY23/24	FY24/25	FY25/26	FY26/27
Base: simple extrapolation from 2 years of data ending June 2023 (gives a model of 53.64 million for FY22/23 and 5.2% growth each year)	56.43m	59.35m	62.43m	65.67m
Effects of altering prescription co-payments	0.00%	-0.50%	-1.00%	-1.50%
Ongoing effects of removing COVID-19 restrictions	2.23%	2.23%	2.23%	2.23%
Effects of the Minor Health Conditions service	0.28%	0.00%	0.00%	0.00%
Effects of change in rate of population growth	0.20%	0.20%	0.20%	0.20%
Forecast initial dispensing volumes	**57.96m**	**60.49m**	**63.31m**	**66.26m**

[5] A fuller report is available on request. Te Whatu Ora. Integrated Community Pharmacy Services Agreement – February 2024 forecast of demand and expenditure. Te Whatu Ora, 20 February 2024.

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- repeat dispensing volume: based on a varying percentage of the estimates of initial dispensing volumes for the financial year period
- Long-Term Conditions (LTC) adherence support service: an annual growth of 3.5%
- immunisation services: 3% growth for FY23/24, then a 5% increase for subsequent years
- Community Pharmacy Anticoagulant Management Services (CPAMS): 5% service fee uplift (as per ICPSA variation 5, 2023) with reducing volumes
- locally commissioned services: to remain constant at $5 million per annum
- the FY22/23 price uplift: 5% applied across the services lines as per ICPSA variation 5, 2023.

Sensitivity analysis

5. There is much uncertainty in this forecasting. Major areas of uncertainty include:
   - initial and repeat dispensing volumes
   - the impact of the removal of the standard $5 prescription co-payments (1 July 2023) and the impact of the proposed reinstatement from 1 July 2024
   - global medicines supply disruptions requiring increased use of monthly dispensing (rather than 3-months' supply all at once), increased use of unapproved (section 29) medicines with additional acquisition costs and service fees
   - the demand for other pharmacy services, including immunisation services, and the impact of childhood immunisations being available through community pharmacies (if this initiative progresses).

6. A sensitivity analysis has therefore been undertaken. Based on this, the following range of outcomes on ICPSA service expenditure are estimated:

Ranges	FY22/23	FY23/24	FY24/25	FY25/26	FY26/27
Low end		$717m	$738m	$752m	$770m
Base case	$658m	$731m	$759m	$786m	$818m
High end		$745m	$780m	$820m	$867m

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Appendix 3

Explanation for the relatively large percentage increase between FY22/23 and FY23/24 in the ICPSA forecast of demand and expenditure

There is a relatively large estimated percentage increase between F22/23 (actual) and F23/24 (forecast) of 11.2%. Major drivers include:

- a 5% price uplift awarded under ICPSA variation 5, 2023. There is no price uplift applied to the service lines in subsequent years, as Health NZ price uplift offer is unknown for out-years
- under ICPSA variation 5 (for FY23/24) the percentage price uplift was not app ied acro s all service lines but weighted to specific lines. The sum of changes in service line fee structures resulted in a total 5% price uplift across the tota forecast ICPSA service expenditure. The initial dispensing Base Service Fee was increased 13.54%, and the repeat dispensing Repeat Base Service Fee increased 7.92%. These two fees are weighted approximately 70/30 (initial/repeat dispensings) resulting in an average increase in Case Mix fee of 11.86%
- estimated growth in the general populat on a d an aging population contributing an estimated 2.50% increase
- estimated growth in the pharmaceutical margin spend. This is driven by the units cost of pharmaceuticals, which intern is driven by Pharmac's medicine investment decisions. In out years, it is anticipated that Pharmac medicines investments through the combined pharmaceutical budget (CPB) will reduce as Pharmac invests in intravenous cancer treatments that supplied outside of the ICPSA so do not impact the community pharmacy demand and expenditure forecast
- a 29.48% increase in the immunisation administration fee (ICPSA variation 5)
- introduc ion of a new immunisation co-administration fee for influenza and shingles co-administration
- estimated growth in initial dispensing volumes in 2023/24 attributed to the removal of the standard $5 presc iption co-payment 1 July 2023 and population growth
- service fees associated with the minor health conditions proof of concept introduced to support the system pressures minimization activities.

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Aide Mémoire

Primary Health Organisation Funding

To:	Hon Dr Shane Reti, Minister of Health	Reference:	HNZ00039029
From:	Abbe Anderson, National Director Commissioning	Due Date:	7 March 2024
Copy to:		Security level:	In Confidence

Contact for telephone discussion (if required)			
Name	Position	Telephone	1st contact
Martin Hefford	Director, Living Well, National Commissioning	S 9(2)(a)	x
Astuti Balram	Group Manager, Primary Care, Living Well, National Commissioning		

Purpose

1. This Aide-Mémoire provides you with information you requested on PHO funding arrangements, including PHO balance sheets, management fees, flexible funding pools and incentive programmes.

Discussion

PHO Management Services Fees

2. PHO funding for 2023/24 is expected to total around $1.3 billion (about 5% of total Health NZ spending). The majority, $1,079 million is capitation funding targeted directly to general practice, while PHOs also receive additional funding for services and performance that they manage.

Capitation	1079.3
Management Services	36.3
Care Plus*	87.1
Services to Improve Access*	60.1
Health Promotion*	12.8
Immunisation	40.9
TOTAL	1,316.50

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3. PHOs receive $36.3 million in annual management services fees for tasks set out in the PHO Services Agreement (PHOSA). These fees are calculated based on the enrolled population, and with a scaled payment based on the size of the enrolled population with the larger PHOs receiving the lower fees per enrolled person. These fees constitute around 3% of PHOs' total capitation funding. PHOs are expected to pass 100% of the capitation funding on to GP subcontractors. The management fee is to fund the required clinical governance, relationship management data and digital, administration, communication, governance, and financial systems that enable delivery of the PHO functions.

4. PHOs may also receive management fees to deliver additional services outside of the PHOSA, that they are contracted for by Health New Zealand | Te Whatu Ora (Health NZ) or other entities. The management fees are often an agreed percentage of the total value of the contract and will vary based on the estimated resources the PHO may require to deliver the service. For instance, a PHO contracted to delive a retinal screening service would be expected to use around 10% of th funding for organisational overheads.

PHO Reserves

5. PHOs are required to be not-for-profit public benefit entities. Not-for-profit entities may still achieve surpluses, and may own subsidiaries that are for-profit, but any surpluses they make must be used to fund additional services or to further their charitable purposes and canno be distributed to 'shareholders' or trustees. PHOs are required to publicly report their financial results annually.

6. PHO 'reserves' may include retained earnings (profits) from delivering services or from other trading activities. Some PHOs run large businesses outside of their capitation funding activity. Some provide services such as information management, or own subsidiaries that contract separately (e.g. Whakarongarau). Some own and operate general practice services. Reserves may be used at the discretion of the PHO boa d for any charitable purpose or to invest in new services or infrastructure. PHOs are also expected to have sufficient reserves to wind up the organisation in the event that Health NZ gives notice to quit the PHO agreement. Net assets on PHO balance sheets would include the value of any practices and properties they own.

7. PHO balance sheets often also reveal earnings in advance of expenditure. Earnings in advance are funds that have been provided, usually by Health NZ, for a specific purpose, that have ot yet been fully expended. This may be due to timing and phasing of revenue and expenditure, or it may indicate a true recoverable underspend.

8. While PHOs publish annual financial reports, they vary in what they include in these reports. Health NZ will work with PHOs over the next few weeks to collate financial information to provide a clearer view of the current state, and to explore opportunities for the application of the funding. We will then update your office.

PHO Flexible Funding Pool

9. PHOs received $160 million as a flexible funding pool, which includes Care Plus, Services to Improve Access and Health Promotion funding as outlined below.

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	Flexible Funding Pool streams	2020/21	2021/22	2022/23
Northern	Care Plus	$29.9m	$31.4m	$32.0m
	Services to Improve Access	$25.6m	$26.1m	$26.0m
	Health Promotion	$4.8m	$4.9m	$5.0m
	Subtotal	**$60.3m**	**$62.4m**	**$63.0m**
Te Manawa Taki	Care Plus	$16.4m	$17.5m	$18.0m
	Services to Improve Access	$14.4m	$14.9m	$15.0m
	Health Promotion	$2.5m	$2.5m	$2.6m
	Subtotal	**$33.3m**	**$35.0m**	**$35.5m**
Central	Care Plus	$15.9m	$16.7m	$17.0m
	Services to Improve Access	$11.6m	$11.9m	$11.9m
	Health Promotion	$2.4m	$2.4m	$2.4m
	Subtotal	**$29.9m**	**$31.0m**	**$31.3m**
Te Wai Pounamu	Care Plus	$18.5m	$19.6m	$20.1m
	Services to Improve Access	$6.6m	$6.9m	$7.1m
	Health Promotion	$2.8m	$2.9m	$2.9m
	Subtotal	**$27.9m**	**$29.4m**	**$30.1m**
National	Care Plus	$80.7m	$85.3m	$87.1m
	Services to Improve Access	$58.3m	$59.8m	$60.1m
	Health Promotion	$12.4m	$12.7m	$12.8m
	Total	**$151.4m**	**$157.8m**	**$160.0m**

10. PHOs use the PHO Flexible Funding Pool differently, which is the intent of the pool, enabling PHOs to choose the best service mix from the pool to support their communities. Some PHOs apportion the funding streams directly to general practices while others apportion it to projects and services delivered at a PHO level. Use of the flexible funding pool is required to be agreed with Health NZ, and arrangements for this are devolved locally.

11. From the information currently available, there are themes on how the Flexible Funding Pool is used across the country:

- Improving access to achieve equity of outcomes: localised solutions that extend primary care to specific settings / clinics for groups of people who may not otherwise access, or not have timely access, to primary care; for example, RIMA (Refugee, Internally displaced person, Migrant and Asylum seeker);
- Long-term conditions management: for example, cardiovascular disease and diabetes;

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- Preventative General Care: for example, breast, bowel, and cervical screening programmes, cardiovascular disease risk assessments, green prescriptions, mental health and wellbeing support, immunisations;
- Employment of specialist roles to provide extended care in the community: for example, dietitians, podiatrists, clinical pharmacists, social workers, school nurses;
- Direct patient-related services: for example, intravenous treatments for cellulitis insulin initiation, cardiac rehabilitation, minor surgery, smoking cessation, palliative care, sexual health and contraception, dental care;
- Infrastructure: for example, modernising general practice patient management systems, health analytics programmes (e.g. Dr Info), Whakarongorau telehealth services, interpreters.

12. More detailed information on the use of the flexible funding pool will be collected as part of the meso-level design project and the capitation p anning that Health NZ carries out with the sector. Better understanding the current uses of the fu ding pool will help inform planning for its future use.

PHO Incentive Programme

System Level Measures

13. The System Level Measures (SLM) programme was introduced in 2016. It is included in the PHOSA as a whole-of-system continuous quality improvement and integration framework that provides a system-wide view of performance. It also introduced some performance-based payments as incentives

14. The aim of the SLM programme is for Health NZ and PHOs to work with health system partners to improve performan e in riority areas. The 2023/24 SLM guidance provided to PHOs highlighted that, as much as possible, local alliances must focus their improvement milestones, quality improvement activities and contributory measures to address the gaps in performance. All PHOs submitted SLM improvement plans, which have been approved by Health NZ as they met the requ red assessment standards, including quantifiable targets and clear actions for improvements.

15 There are six SLMs as follows:

Acute hosp tal bed days per capita	Milestones achievement relates to a financial incentive for these measures.
Ambulatory sensitive hospitalisation (ASH) rates for 0 to 4-year-olds	
Patient experience of care	
Amenable mortality rates	Milestones are agreed for these measures but are not financially incentivised.
Youth access to and utilisation of youth appropriate health services	
Babies who live in a smoke-free household at six weeks post-natal	

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16. The milestone for each SLM is based on a local agreement between the PHO and local Health NZ teams, previously Alliance groups, based on trend data and baseline and what they deem appropriate, given the needs and priorities of communities.
17. Three common themes of improvement activity have emerged from the SLM 2023/24 improvement plans: increasing immunisation rates, general practice enrolment drives, and long-term conditions management. Most PHOs have incorporated the Government's focus of increasing immunisation rates as a common contributory milestone in the SLM plans, which means that as part of this programme they sho ld be tracking and focusing on performance against this measure.

Incentive Payments and Opportunities for Change

18. The SLM funding, of around $26 million per annum, is based on an annual amount of $5.33 (excl. GST) per enrolee.
19. Each measure that attracts an incentive payment receives a relative proportion of t e final performance payment payable if the milestone or target is achieved.
20. The PHO incentives are linked to the PHO Services Agreement. Changes must go through the national PHO Services Agreement Amendment Protocol (PSAAP) Group, which has not been active since 2022 In discussion with the primary care partners, Health NZ has called for a PSAAP meeting on 15 March 2024. While the first meeting will focus on the PSAAP protocol, discussion on the incentive programmes will be an agenda item for future meetings.
21. While there are merits in the current SLM, we intend to review and redesign the system-level measure programme as part of our pr mary care capitation redesign work to a more cohesive nationally aligned programme. There may be an opportunity to redirect the existing incentives to target improvements in enrolments, which would contribute to primary care access and the Government immunisation target.

Next steps

22. Health NZ will cont nue to compile information on PHO reserves, progress development of an updated incentive programme and consider a policy to cease the geographical expansion of PHOs.
23. You are due to receive an Aide-Mémoire on 20 March 2024, as additional advice following your meeting with GenPro. This will include advice on the Annual Statement of Reasonable Fee Increases (ASRFI) and alternative pathways, and on how best to encourage immunisations as part of the six-week GP check.

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Aide-Mémoire: Critical Care beds

To:	Hon Dr Shane Reti, Minister of Health	Reference:	HNZ00039526
From:	Mary Cleary-Lyons, Director, National Clinical Networks, Hospital and Specialist Services	Due Date:	13 March 2024
Copy to:		Security level:	In Confidence

Contact for telephone discussion (if required)			
Name	**Position**	**Telephone**	**1st contact**
Mary Cleary-Lyons	**Director, National Clinical Networks, Hospital and Specialist Services**	S 9(2)(a)	x
Fionnagh Dougan	National Director – Hospital and Specialist Services		
Brenda Wills	Programme Lead – Critical Care, Hospital and Specialist Services		

Attachments
Appendix 1: Number of resourced Critical Care beds as of December 2023
Appendix 2: Final allocation of funded beds by region by 30 June 2025
Appendix 3: Number of resourced Critical Care beds across the programme timeline

Purpose

1. This Aide-Mémoire provides you with an update on critical care provision in New Zealand, including the number and distribution of adult and paediatric critical care (intensive care unit (ICU) and high-dependency unit (HDU)) beds across New Zealand, an international comparison, and an update on the critical care bed expansion programme and forward plan.

Background

2. Critical care refers to specialist care given to patients when rapid, potentially reversible, life-threatening diseases or injury occur, for example, a major accident, a severe infection or coma. It involves concentrated support for each patient, often requiring one-on-one nursing support over extended periods.

3. The term 'intensive care beds' is often used as a general term to describe, variably, intensive care beds, high-dependency beds, and coronary care beds. However, specific bed types and units are subset(s) of critical care.

4. In addition to servicing acute demand, critical care manages a high volume of planned care patients (cardiac and others) who require specialised support immediately after their surgery.

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5. Critical care is provided in multiple settings, including ICU, High Dependency Units (HDU) and paediatric and neonatal ICU. Critical care staff also provide support to and assessment of patients in hospital wards and co-ordinate and staff the transport of critically ill patients within and between hospitals. The table below provides you with high-level definitions:

Intensive care	Located in Level I, II, or III ICUs, requires trained nursing staff available 24/7 and a minimum staff-to-patient ratio of 1:1 for ventilated patients There are adult and neonatal ICUs across New Zealand and one paediatric unit at Starship Hospital.
High Dependency	Found in Level I, II, or III ICUs or separate HDUs, features trained nursing staff available 24/7 with a minimum staff-to-patient ratio of 1:2 and may offer non-invas ve ventilation or high-flow oxygen.
Coronary care[1]	Coronary care beds, when situated in Critical Care Units (CCU), are staffed with coronary trained nursing staf and provide continuous electrocardiogram (ECG) monitoring and specialised care from cardiologists or general physicians.

6. Critical care patients require the most complex, intensive, and costly care within the inpatient hospital environment. A range of staff groups from medical specialists through nursing to allied health and administration are di ectly involved in the delivery of critical care. Patients also access high volumes of radiology, laboratory services and pharmaceuticals. In addition, maintenance of h gh-tech equipment requires specialised staff.

7. While there is not a proven correlation between lower patient mortality and the number of critical care beds, a shortage of critical care capacity can lead to challenges. These challenges include higher rates of cancelled elective procedures, which can increase patient risk and negatively impact patient and family experiences.

8. Workforce shortages are a key driver for a lack of critical care beds. Persistent workforce shortages, especia ly in nursing, leave beds unable to be resourced, requiring simultaneous workfor e and capacity improvements. Units can struggle to recruit senior medical staff and specialist nurses[2] which recently impacted paediatric care in Auckland[3]. Sta f also require a significant period of training. Therefore, there is a limit to the number of beds that can be stood up simultaneously or over a short period of time in any one unit.

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1 Coronary Care is not included in the Government funded expansion programme. Funding was approved for mixed Critical Care units to deliver additional ICU and HDU beds.

[2] Recent vacancy data outlines the need for additional staff across critical care, including 40 SMOs, 30+ RMOs, 300+ nurses, and 100+ other roles.

[3] In late 2023, the Auckland paediatric critical care unit developed and implemented a targeted recruitment and retention plan. From this, the unit is on track to open three of the seven beds by June 2024, with the remainder in 2024/25 (paragraph 18 for further information regarding resourced beds).

9. A Critical Care Sector Advisory Group (the Advisory Group) agreed in early 2023 to employ a recruitment team specific to critical care, with individuals having both a national and regional focus.

10. Additional critical care beds provide surge capacity in the event of a pandemic or other event that results in patients needing critical care. They will also enable more planned procedures, which routinely require a critical care bed post-operatively, to be completed.

Critical Care bed distribution across New Zealand

11. Appendix 1 presents a snapshot of the resourced critical care bed capacity across New Zealand by region as of December 2023. The highest numbe s of beds are in the Northern region (117), while the other regions (Te Manawa Taki, Central, Southern) have between 63 and 70 beds.

International Comparison

12. Appendix 2 highlights that NZ has a relatively low number of ICU beds pe capita compared to other OECD countries. It is reported that NZ has 3.6 beds per 00,000 population[4].

13. This is among the lowest and is considered too low. Direct comparison however, even with Australia, may not be appropriate. For example, Australia has 9.4 beds per 100,000. Some of this difference can be accounted for by the considerable resourced ICU capacity available in private hospitals which is integrated nto their service delivery models. Although this accounts for some of the gap, it does not fully account for the difference between the two countries.

14. However, it is important to note that direct comparisons between OECD countries are challenging due to differences in health systems, funding, bed definitions, counting methodologies, and models of care.

Expansion and Forward Plan

15. In response to the growing demand on critical care services, the previous Government announced funding of $544 million in operational expenditure in Decembe 2021 to increase critical care capacity. We established a critical care expansion programme accordingly.

16. Funding has been targeted at increasing capacity and capability, with districts remaining responsible for a base level of service. From 1 July 2024, full annual funding of $140 million is expected to be distributed across the four regions to sustainably fund the agreed bed uplift (of 85 beds by June 2025) and investment in related services.

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[4] For example, from the OECD's 'Beyond Containment: Health system responses to COVID-19 in the OECD,' report and the OECD's Economic Survey of New Zealand published in January 2022

17. Funding was allocated across years on the following basis:

Year	Funding	One-off	Permanent	Comments
2021/22	$35.3m	$35.3m surge costs	Nil	Spread across regions on activity and population basis to fund surge costs in both critical care and ward beds
2022/23	$86.3m	$5.3m workforce initiatives	$81.0m	Agree timing of new beds on regional basis to apply funding
2023/24	$140.2m	Nil	$140.2m	Permanent uplift of up to 85 critical care beds
2024/25	$140.2m	Nil	$140.2m	Ongoing permanent uplift of 85 critical care beds
Outyears	$140.2m	Nil	$140.2m	Ongoing permanent uplift of 85 critical care beds
Total	$542.2m*	$40.6m	$501.6m	

*Operating funding of $1 million was allocated each year in 2021/22 and 2022/23 to meet the cost of a team within the Infrastructure and Investment Group of Health NZ to support the completion of the capital projects.

18. Appendix 3 provides an overview of the regional allocation of the 85 additional beds to be funded by June 2025. In summary, Northern will have 35, Te Manawa Taki 11, Central 15, and Southern 24.

19. The allocation of the increase in beds is deliberately spread across both tertiary and secondary units in each region, with the aim of improving capacity, capability, and equity of access at all levels. Maintaining patients in a secondary unit enables tertiary units to deliver higher volumes of planned procedures and also retain expertise for patients only they can manage. Increasing secondary capacity also reduces inter-hospital transfers for patients who do not need tertiary critical care.

20. Appendix 4 provides an overview of the number of resourced critical care beds across the critical care expansion programme timeline (opening position as of 1 July 2022, position as of 1 January 2024, and the funded position as of 1 July 2024). Note that a number of these funded beds will not be resourced until June 2025.

21. Confirmed funding allocations for additional beds and capability is scheduled to commence regionally from 1 July 2024. The initiative is expected to resource approximately 65-70 additional beds by June 2024.

22. Addressing workforce shortages is important to ensure the additional critical care beds are resourced. Recruiting to many positions over a short timeframe requires a targeted and agile approach. To date, recruitment efforts have included attendance at conferences, job fairs, a dedicated website, and social media marketing. At this point in time, we expect that all beds will be resourced by June 2025.

23. Regions are committed to resourcing beds as quickly as practicable over the next 18 months. As noted, they are simultaneously building their capability to deal with more complex patients, strengthen transport services, provide outreach services into hospital wards, and increase regional collaboration to ensure optimal use of capacity. This work is progressing well in all regions.

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Appendix 1: Number of resourced Critical Care beds as of December 2023

	Region	Facility	Dec 2023
Northern	Northland	Whangarei	8
	Waitematā	North Shore	14
		Waitakere	0
	Auckland	Auckland CVICU	26
		Auckland DCCM	26
		Starship	22
	Counties Manukau	Middlemore	21
			117
Te Manawa Taki	Bay of Plenty	Tauranga	13
		Whakatane	4
	Lakes	Rotorua	7
	Tairāwhiti	Gisborne	4
	Taranaki	Taranaki	6
	Waikato	Waikato	29
			63
Central	Capital & Coast	Wellington	23
	Hutt Valley	Hutt	6
	Hawke's Bay	Hawke's Bay	13
	MidCentral	Palmerston North	8
	Wairarapa	Wairarapa	6
	Whanganui	Whanganui	6
			62
Southern	Canterbury	Christchurch	27
	Nelson Marlborough	Nelson	9
		Wairau	4
	South Canterbury	Timaru	4
	Southern	Dunedin	16
		Southland	6
	West Coast	Greymouth	4
			70
	Total		**312**

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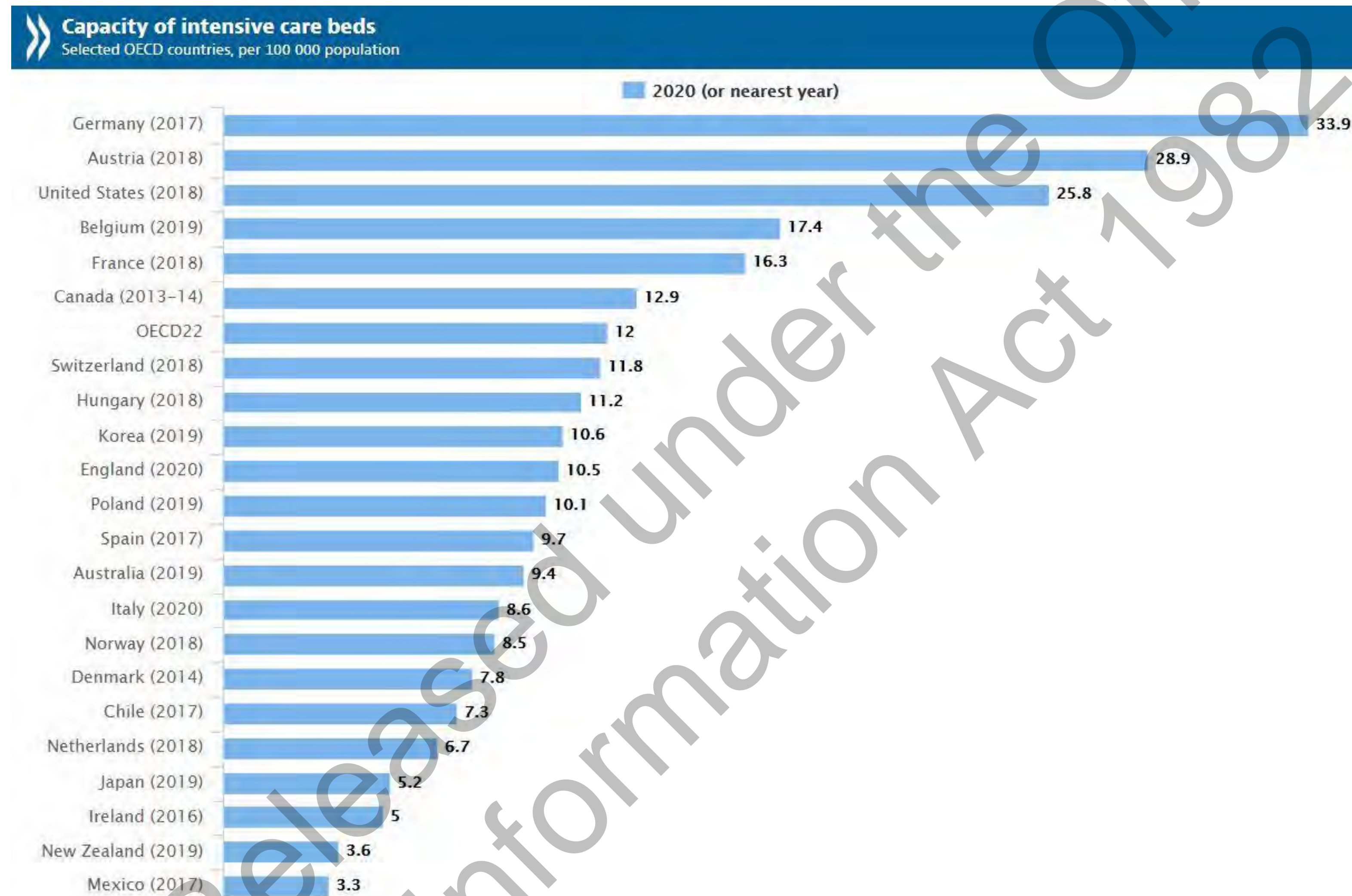
Appendix 2: Capacity of intesive care beds in OECD countries



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Appendix 3: Final allocation of funded beds by region by 30 June 2025

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Appendix 4: Number of resourced Critical Care beds across the programme timeline

REGION	Opening Position 1 July 2022	Resourced Beds Advised 1 Jan 2024	Final Funded Position 1 July 2024
NORTHERN			
Whangarei	8	8	9
North Shore / Waitakeri	14	14	18
Auckland CVICU	22	26	32
Auckland DCCM	17	26	26
Starship	22	22	29
Middlemore	18	21	22
TOTAL:	**101**	**117**	**136**
TE MANAWA TAKI			
Tauranga	10	13	14
Whakatane	4	4	4
Rotorua	4	7	7
Gisborne	3	4	5
Taranaki	5	6	6
Waikato	28	29	29
TOTAL:	**54**	**63**	**65**
CENTRAL			
Wellington	22	23	31
Hutt	4	6	6
Hawke's Bay	11	13	14
Palmerston N	6	8	7
Wairarapa	6	6	6
Whanganui	3	6	3
TOTAL:	**52**	**62**	**67**
TE WAIPOUNAMU			
Canterbury	21	27	33
Nelson	7	9	7
Wairau	4	4	4
South Canterbury	4	4	6
Dunedin	9	16	19
Invercargill	6	6	6
West Coast	4	4	4
TOTAL:	**55**	**70**	**79**
TOTALS	**262**	**312**	**347**

Note: This table outlines the number of resourced beds as of 1 January 2024 and the funded position as of 1 July 2024. Note that the funded beds will not be resourced until July 2025.

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Aide Memoire: Central Lakes Proposal

To:	Hon Dr Shane Reti, Minister of Health	Reference:	HNZ00040417
From:	Fionnagh Dougan, National Director – Hospital and Specialist Services	Due Date:	18 March 2024
Copy to:		Security level:	In Confidence

Contact for telephone discussion (if required)			
Name	**Position**	**Telephone**	**1st contact**
Fionnagh Dougan	**National Director – Hospital and Specialist Services**	S 9(2)(a)	x
Aroha Metcalf	Group Manager, Local Commissioning, Te Waipounamu		

The following departments/agencies have been consulted
N/A

Attachments
N/A

Purpose

1. You have received from the MP for Southland a proposal for $250,000 for a business case aimed at defining improved healthcare access and levels of service in Central Lakes.

2. This paper provides context to support your meeting regarding the proposal on Wednesday, 20 March 2024, with suggestions of how the proposal can be aligned with an integrated approach to planning. This approach is led by the Regional Wayfinder, Te Waipounamu, and the hospital clinical service planning process.

3. Officials in attendance online are:
    - Fionnagh Dougan, National Director, Hospital and Specialist Services
    - Hamish Brown, Group Director Operations – Southern, Hospital and Specialist Services
    - Aroha Metcalf, Group Manager, Local Commissioning, Te Waipounamu

4. Refer to Appendix 1 for a summary of the proposal and an overview of the Central Lakes area.

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Approach

5. It is important to note that capital investment is not the solution for improving service delivery for this population. Improving coordination and integration of services can deliver improved access. Building more infrastructure will result in higher operation costs that is not necessary to meet the needs of this area in the coming years. However, this localised planning approach should focus on future need, of which part of is increased capacity to meet increasing population projections.

6. The approach that we recommend for this region is integrated healthcare planning with private hospitals, community, and specialist care, with a focus on increased access to local healthcare and reduced the need for patients to tra el.

7. The likely outcome of this work is that there will be a need for better access to publicly funded diagnostics, and better use of the relationship with the private hospitals and local communities.

8. There is also a need for more community ser ices including musculoskeletal team and community mental health centres.

Discussion

9. The request to support and fund a s rategic business case, needs to be considered in the context of the national planning approach and fiscal constraint.

HNZ needs to be fiscally disciplined

10. The healthcare system across NZ faces significant and ongoing budget constraints, particularly concerning sustaining operational costs. This is a critical consideration regarding any apital expenditure, whether publicly or privately sourced. Operational and capital expenditure requirements are considered hand-in-hand to ensure that there is sufficient resourcing to provide high quality and safe health services for the community.

11 In addition, in this fiscally constrained environment investments need to be considered relative to one another and population health need.

A business case would be premature but integrated service planning would not be

12. We a knowledge and support the Central Lakes region's commitment to a partnership approach (including iwi, local authorities, and public/private sector stakeholders) with healthcare delivery and place-based planning. This is consistent with the Pae Ora (Healthy Futures) Act 2022.

13. However, we do not support funding a business case to be completed by external parties to HNZ from a planning perspective.

14. A business case for Central Lakes needs to be underpinned by the local service planning for Central Lakes will occur in with the wider Southern Region considering

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how people access care across the region and the continuum of care from community to primary care to hospital services and back home.

15. Mandating and funding a business case now would not add anything to the unfolding national planning framework or to meeting this area's needs. If anything, a business case could create undue expectation or pressure on evidence-based investment.

Opportunities to work together

16. We agree that there is a growing population and therefore need in the Central Lakes area and are committed to working with community leaders and experts to design, commission and deliver services that meet the communities' current and emerging needs.

17. We also acknowledge the desire of those submitting the proposal to allow loca interests to develop their health-related aspirations. Community led planning and commissioning approaches are already underway in Te Waipounamu. HNZ is committed to continuing to work with community on the specifics.

18. This will be led by the regional Commissioning Team with the support of Hospital and Specialist Services.

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Appendix 1

Summary of Proposal

19. Central Lakes region stakeholders are interested in how they can work with you to ensure that access to healthcare is fit for purpose into the future.

20. The Central Lakes region has provided you with a proposal sponsored by Joseph Mooney, Member of Parliament for Southland, seeking:

    a. A mandate to Health New Zealand / Te Whatu Ora to work collaboratively with Central Lakes leadership to develop the strateg c business case, considering the following:
        i. Crown-iwi and other public-private partnership opportunities
        ii. identification of potential locations for healthcare facilities.
        iii. alternative options to fund infrastructure.
        iv. the potential to increase operational expenditure.
        v. Funding from the Crown for a strategic business case.

    b. $250,000 funding from the Crown for a strategic business case.

21. The stated purpose of the project is:

    to increase health services in Central Lakes through an investment in services and infrastructure, extending benefits to the broader Southern region.

22. The proposal contemplates that the strategic business case development would occur alongside master planning and clinical services planning for Southern and draws on early-stage planning undertaken by the former Southern DHB.

Central Lakes Overview

23. 'Central Lakes' refers to areas encompassed by Central Otago District Council and Queenstown Lakes District Council. The area includes Queenstown, Arrowtown, Kingston, Glenorchy, Wanaka, Luggate, Lake Hawea, Cardrona, Cromwell, Clyde, Alexandra, Roxburgh and Ranfurly.

24. The populat on of Central Lakes is 75,000 people[1]. Two thirds of the resident population are aged 15-64 years, 16% are children and young people aged 0-14 years and the remaining 16% are aged 65 years and over.

25. It is predicted that the population will grow to 129,162 by 2054 and that peak day visitors will increase from 97,837 in 2024 to 162 998 in 2024[2]. The driving factor of the population growth is the arrival of newcomers from overseas and from other parts

[1] Statistics NZ population demographics for 2023, by district.
[2] demand-projections-summary-march-2022-2023-to-2053.pdf

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of the country. In the last 12 months this area has seen a net international migration gain of 2,672 and internal migration gain of 1,492[3].

26. Health services for the population are provided in primary care including general practice, pharmacy and after-hours services, ambulance services, other community services, and limited hospital-based services. There are also community based mental health services.

27. There are two hospital-based service providers of publicly funded healthca e:

- **Lakes Hospital in Queenstown**; this is owned and operated by Health New Zealand (HNZ). Care is provided in 12 inpatient-beds, 5 pos -natal maternity beds and has a 10-bed emergency department with some diagnostic service capability. If patients require higher acuity care or more complex diagnostics, they are transferred to Invercargill or Dunedin Hospitals (and in some cases Christchurch).

- **Dunstan Hospital in Clyde**; is a community trust managed hospital with 24 beds providing acute in-patient management and rehabilitation. There is limited emergency department care, and a proportion of the urgent care provided requires a co-payment to access after-hours primary care.

28. In addition, two primary birthing units are being constructed in the Central Lakes area. One is situated in Clyde, and the other in Wanaka and will be commissioned in late 2024 and late 2025 respectively

29. Lakes is supported by secondary and tertiary services in Invercargill and Dunedin (including the planning for the New Dunedin Hospital) and Christchurch (for example pediatric oncology), however significant travel time is required (Invercargill 3 hours, Dunedin 3-4 hours, and Christchurch 6 8 hours by road).

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[3] NZ.Stat (stats.govt.nz)

Meeting Briefing

Hira Programme Update

To:	Hon Dr Shane Reti, Minister of Health	Reference:	HNZ00038905
From:	Leigh Donoghue, Chief Data and Digital	Due Date:	18 March 2024
Copy to:		Security level:	In Confidence

Contact for telephone discussion (if required)			
Name	**Position**	**Telephone**	**1st contact**
Leigh Donoghue	**Chief Data and Digital**	S 9(2)(a)	x
Michael Dreyer	Director, Sector Digital Channels		

The following departments/agencies have been consulted
Ministry of Health

Attachments
Appendix 1: Achievements to date – March 2024

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Meeting details	**9.00am to 9.30am, Wednesday 20 March 2024**
	Minister's office
Expected Attendees	Margie Apa, Chief Executive Leigh Donoghue, Chief Data and Digital Michael Dreyer, Director Sector Digital Channels Lara Hopley, Director Clinical Informatics Darren Douglass, Director Strategy and Investment Maree Roberts, Deputy Director-General, Strategy Policy and Legislation
Purpose of meeting/visit	You have requested an update on the Hira programme and specified the areas that this should cover.

Hira Programme

1. The Hira programme is a local response to a common problem across health systems: the difficulties associated with accessing key patient information. Health and wellbeing information is currently stored in diffe ent places, in different formats, and is hard to access across healthcare settings. This means healthcare providers cannot always get a full picture of a person's health information, while people must often repeat their health information and history several times to different service providers. This problem is compounded in New Zealand due to the patchy and fragmented nature of the digital landscape – a legacy of the way that the previous health system was structured and historical underinvestment in IT systems and standards.
2. Health systems have addressed this historically through investment in health information exchanges (HIEs). Electronic health information exchange (HIE) allows doctors, nurses, pharmacists, other health care providers and patients to appropriately access and securely share a patient's key medical information electronically, thereby improving the speed, quality, safety and cost of patient care.
3. Early HIE platforms sought to provide clinicians with fast and appropriate access to patient's key medical information through a Summary Care Record (SCR). A good example of this is the NHS' Emergency Care Record which was rolled out across England from 2004. HealthOne, introduced in early 2012 following the Christchurch earthquake, is local exemplar of this model – primarily focused on providing healthcare providers with access to key medical information such as patient's test results, allergies and medications.
4. Second generation solutions extended the focus to consumers – providing patients with online access to their medical records. The goal here was to empower health consumers and carers, thereby enabling them to become more active participants in managing their own health and wellbeing. Australia's My Health Record (MHR) is a good example of this. This service, introduced in 2012, has progressively grown with

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more than 23M records available today (covering 91% of eligible patients, including more than 300K people who have opted back into the service in the past 12 months after previously opting-out or cancelling). Usage of the service by health providers is also rising as the amount and quality of health information increases[1].

5. Notwithstanding major investment and significant progress by these countries over the past decade, the limitations of these HIE solutions have become apparent. These relate to a lack of standardisation in terms of how data and documents are shared and stored, as well as wider barriers to information sharing and enabling industry innovation. This limits the extent to which information can be aggregated and processed using machine learning techniques and tools – an increasingly important consideration as the amount of digital health information grows and workforce capacity remains constrained. It further limits the capacity of third parties to innovate on the base platforms – e.g. integrate health information with wider data sources or behavioural interventions (e.g. gamification) to improve health outcomes. To address this and wider interoperability challenges, several countries have embarked on major infrastructure modernisation programmes, including Australia. The European Union, for instance, has recently committed to implementing a common standard based on the International Patient Summary, to enable cross-border information sharing across members.

6. New Zealand had the benefit of mobilising a national digital health infrastructure programme after other countries. Based on extensive sector consultation and lessons from overseas, a conscious decision was made o invest in modern infrastructure and methods (including adopting international standards) rather than build on outdated legacy solutions. The Hira programme reflects this.

Structure of the Hira Programme

7. In 2021, Cabinet endorsed a Hira programme case for $553.9m WOLC for services to be delivered ove three tranches as outlined below. The original programme business case proposed three tranches, this approach reflected the organisational structure, with the change in structure and the shift in focus to a continuous improvement approach we are recommending a change where investment is aligned to specific priorities and business outcomes.

8. The programme bu iness case included a detailed business case for $147 million to implement the first tranche. Delivery commenced early in 2022:

   Tranche one

   Tranche one is foundational. It has been described as putting in place the pipework or plumbing required for a modern, digitally enabled health and disability system. This includes technology enablers such as digital identity and interoperability services.

   The centrepiece of this tranche is the introduction of a national digital health record system with the New Zealand patient summary (based on the HISO

[1] Statistics (digitalhealth.gov.au)

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International Patient Summary) available to consumers and healthcare providers by mid-2024.

Tranche two

Tranche two, if approved, will be completed by mid-2026. It would extend the range of health data, eligibility and entitlement information available through the national digital health record service and include a focus on health literacy to support the adoption of Hira services to reduce the “digital health divide” This tranche would also address wider barriers to information sharing, noting that difficulty accessing information adds cost and delays for consumers providers and funders, while impeding health industry innovat on.

Tranche three

Tranche three would follow subject to approved funding and complete twelve months later. It will connect Hira services more widely across the health and disability system and further expand access to relevant datasets, noting the depth and breadth of health information available through the nationa dig tal health record service is a key factor in driving wider usage and value As the volume of data available grows, new ways will be required to make this more useful for consumers, clinicians and providers. Accordingly, tranche three will include the application of machine learning tools and methods – essentially moving to an AI-powered national digital health record service.

This final tranche will also improve communication and collaboration to enable New Zealanders to access and interact with health services in a more seamless and consisten way.

Progress to date

9. The Hira programme was mobilised during the COVID-19 pandemic response. This impacted early progress given Health IT management attention was focused on the national vaccine rollout. Tranche 1 further struggled for relevance, alignment and impact dur ng the establishmen of Health New Zealand/ Te Whatu Ora, with a lack of clear business ownership and involvement. This was not helped by the initial aspirations of the standalone programme team that sought to achieve the vision of the three tranches (and address wider health inequities) in Tranche One. This resulted in unrealistic and unachievable expectations being set, which progressively diminished confidence in the programme.
10. The programme was deliberately slowed (reducing spend) in the second half of 2023 while a significant review and reset was undertaken. This pivot encompassed four elements:
    - Ensuring clarity of scope (and scope containment) by refocusing the programme on its original mission as set out in the Treasury approved business case,
    - Realigning the programme structure and delivery plan to align with wider national digital health modernisation agenda and ensure regular delivery milestones, and

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- Strengthening consumer and clinical involvement, noting the need to be business rather than technology-led, and finally,
- Clarifying the delivery promise – i.e. communicating what exactly will be delivered and when. Scope clarity and delivery transparency are critical with programmes of this nature.

11. Following the successful pivot, the programme has ramped up again (injecting new leadership and skills) and delivery has accelerated with industry engagement reinvigorated. Key industry associations (e.g. HINZ, DHA) have publicly expressed strong support for Hira in the past 3 months and active industry involvement has increased as real delivery has become apparent.
12. Tranche 1 remains focused on establishing critical interoperability capabilities and enabling wider access to key patient health information. **Th se base capabilities are on track for delivery before the end of June 2024.**
13. Tranche 1 has three specific deliverables designed to generate indirect benefits:
    - Through provision of the My Health Record enabling health consumers to have visibility of their health information and enable them to engage n their health outcomes;
    - Clinical access to the Patient Summary view, bringing the key health information required to support clinicians in an unplanned health encounter;
    - A developer portal together with standards and suppor ing services for the vendor community is being implemented to ena le access to key health information via APIs.

Healthcare consumers

- ✓ No longer have to repeat health info
- ✓ Can update own info
- ✓ Quick, easy access to their core health info
- ✓ Can share health info with trusted whānau
- ✓ Their info can be accessed by clinicians throughout the country
- ✓ Can see children's health info
- ✓ Can see health info, even if not enrolled in general practice
- ✓ Access to doctors' notes

Health professionals

- ✓ Can view patients' up-to-date health info – don't have to keep asking
- ✓ Can access patient's information no matter where in NZ they live
- ✓ Can access core set of patient information in acute situations
- ✓ Can access patients' info from primary, secondary, tertiary care, allied health
- ✓ Can make care and treatment decisions based on the latest information
- ✓ Have up-to-date demographic details for patients

14. More broadly, Tranche 1 capabilities fall within three areas:
    - A New Zealand Patient Summary Record aligned to the International Patient Summary (IPS) standard allowing healthcare providers to access key health information nationally.
    - A consumer channel (labelled **My Health Record**), a phone application and website, allowing healthcare consumers/whānau to see their key health information in one place and in Tranche 1, the ability to update some of it. An early release of My Health Record, the website, was launched in December 2023. This is supported by My Health Account, a secure digital identity

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solution so New Zealanders can access their health information digitally through My Health Record, other Patient Portals and similar services.

- A secure, carefully controlled digital ecosystem enabling non-Government applications to access key health information for healthcare consumers and whānau to help people manage their own health and to share their information with providers who are delivering care. Again, this is core component of the Hira vision – enabling industry to access the information through approved, standards-based methods and innovate to more effectively meet consumer and whānau needs and enable better health outcomes.

15. Several Hira-related capabilities have already been delivered, with further capabilities becoming available in the coming months (see Key Milestone table below) as the programme reaches full momentum. A summary of achievements to date is included at **Appendix 1.**

High Level Deliverables (Key Milestones)	Scheduled date
My Health Record Version 1	December 23
My Health Record Version 2	April 24
My Health Record Version 3	May 24
My Health Record Version 4	June 24
NZ Patient Summary – clinical view	June 24
Developer Portal	April 24
APIs available for Vendors to access:	
• Medicines	April 24
• Laboratory reports	April 24
• NHI Demographics	April 24
• Entitlements	May 24
• Medical Warnings	May 24

16. This delivery timeline is aggressive with little schedule contingency remaining. This means that there is limited scope for slippage should late delivery issues be encountered. We recommend that appropriate caution is exercised in terms of official Hira launch announcements.

17. The delivery of new capabilities is central to rebuilding confidence and momentum in the Hira programme. However, longer term success hinges on helping drive wider adoption and use of modern standards and interoperability methods across the New Zealand health ecosystem. This is critical to enabling the efficient and appropriate flow of information across the health sector.

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Cross-border collaboration

18. Significant progress has been made in addressing the challenges of interoperability. This is being led out of North America where the healthcare sector was able to rapidly digitised with federal investment (Meaningful Use programme linked to Obamacare) and the subsequent passage of enabling legislation (21st Century Cures Act, 2016). This is being progressively extended through regulations to address information blocking combined with advancements in the development of standards to enable effective interoperability – e.g. HL7 FHIR-based standards. Large-scale adoption is being further facilitated through Industry Connectathons, events which bring together patients, health informaticians, developers and policy-makers.

19. The Australian Governments are taking major steps to address interoperability. Thi includes direct investment in developing and supporting standards-based bod es and industry events. The Sparked Accelerator is a government-funded community established in Australia to accelerate the use FHIR standards in healthcare information exchange. It creates open standards and works collaboratively with the international FHIR community, and other FHIR initiatives.

20. The Sparked community includes government, technology vendors, provider organisations, peak bodies, practitioner , and domain experts to accelerate the creation and use of national FHIR standa ds in health care information exchange. With the number of vendors operating in both New Zealand and Australia, the common approach and adoption of standards is expected to support vendors with growing their products and market share.

21. There is a significant opportunity for Trans-Tasman collaboration here, noting the overlap between our respective populations clinical colleges, health providers and IT vendors. To this end, we initiated a dialogue with relevant Australian entities to explore how the Hira programme might be involved with Australia's Sparked Accelerator programme. Key opportunities include joint training on the FHIR standard and other standards such as development of the NZ Base of health information which we expect to be closely a igned to the Australian standard. Building on discussions last November at Heal h Tech Week, the Australian Department of Health and Aged Care has now extended a formal invitation to Health NZ to participate in the Sparked Accelerator.

22. We note your prior support for standards-based approaches to address interoperability and Trans-Tasman collaboration in healthcare. S 9(2)(f)(iv)

23. Such collaboration also opens new opportunities in terms of the development of a Summary Care Record to improve cross-border care with local Pacific nations. This is an initiative already being jointly supported by the Australian Department of Health and Aged Care and the Australian Department of Foreign Affairs and Trade (DFAT) through the Sparked Accelerator. S 6(a)

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Stepping up Primary Care engagement

24. We further recognise the need to create stronger buy-in and appetite for Hira among local clinicians, particularly GPs. Health information created by the primary care sector represents a significant component of the patient's overall health information It is information that historically has been difficult to access, yet also represents critical components of the International Patient Summary.

S 9(2)(f)(iv)

Resourcing and Budget Status

26. The number of FTEs currently working on the programme is as follows:

Employees (permanent)	25. 1
Employees (fixed term)	26. 3
Contractors	24. 7

27. Prog amme spend has lagged the original business case, reflecting delays incurred in the early life of the programme. The programme is now on track to deliver Tranche One within the original budget, noting that this will free-up programme contingency funds for other purposes. Details of costs to date and forecast are in the table below:

Approved programme budget (tranche one)	$145,500,000
Spend as of 30 Jan 2024	$38,029,000
S 9(2)(f)(iv)	

[2] HealthOne is a partnership between Pegasus PHO and Canterbury DHB established following the earthquake when they determined that they needed a copy of GP data for patients that moved away from Christchurch and or practices that where physically damaged/destroyed along with the data.

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Te Whatu Ora
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S 9(2)(f)(iv)

Next Steps

28. We are reassessing and replanning future delivery to align to government priorities and to determine which elements can be delivered within operational fund ng and which elements would require Ministerial approval for new funding.
29. The original Cabinet-endorsed programme case outlined services to be delivered over three tranches. S 9(2)(f)(iv) Our revised intent would be to transition Hira Tranche 1 services into operational support in June 2024 and then deliver ongoing improvements incrementally in alignment with Government priorities through a more agile investment model. This would mean not requesting ignificant separate funding for S 9(2)(f)(iv)
30. The slowdown in spending and focus on del very of core capabilities has resulted in an underspend in this financial ye r of $35M. S 9(2)(f)(iv) This will include further work to integrate the NZ Patient Summary Record, a component of My Health Record into sector systems and to continue to deliver improvements in response to agreed priorities, for example expanding the capabilities of the interoperability platform, adoption of standards and the inclusion of discharge summaries, referrals, position in the wait list, clinical letters secondary care bookings into the available health information for vendors, health consumers and clinicians.
31. Achieving the Hira ambition of improved information sharing and usage hinges on data quality and the effective adoption of standards across the health ecosystem. The programme is discovering significant data quality issues exist, a consequence of legacy structures and investment constraints. This will need to be remediated going forward: this will require a coordinated effort across consumers and health providers as well as enabling investment. This must be factored into future costs.
32. S 9(2)(f)(iv)

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S 9(2)(f)(iv)

33. Finally, we will work with the Ministry of Health to consider wider measures to address 'information blocking' noting that access to information and effective information sharing is integral to empowering consumers and communities, and enabling greater industry innovation.

Author: Gerard Keena, Hira Programme Director

Responsible manager: Leigh Donoghue. Chief Data and Digital

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Appendix 1 – Achievements to date – March 2024

The Hira team is strongly focused on “delivering on the promise”. There has been a number of achievements heading towards the 30 June goal of having the New Zealand patient summary available to consumers and healthcare providers through My Health Record.

- **My Health Record** was launched on 6 December 2023. A secure website giving people access to their immunisation records, My Health Record is en bled by the interoperability being put in place by Hira Programme. NZ pa ient summary information will be accessed through My Health Record.

- **Hira Marketplace** is available, providing a single point of entry fo vendors and healthcare providers to find what they need to enable the better flow of health information.

- The **NZ Health Terminology Service** (NZHTS) continues to extend its list of code systems and value sets, with over 40 companies now using the service.

- **InterSystems**, a leading global health technology provider, has become an **early user** of the Hira Programme’s APIs developed by Health New Zealand using the FHIR health data sharing standard InterSystems is delivering the patient administration system for Te Toka T mai Auckland part of Health New Zealand. Using the FHIR-based APIs has several benefits for Te Toka Tumai Auckland’s new patient administration system

- **Hira connector plane** is in production and will be extended to support non-Hira requirements. It provides a single, secure point of access to APIs that are supported by Hira. The connector plane is foundational to Hira – the technology that will enable health information to be securely accessed, shared and updated.

- The My Health Account team has completed **adult-to-adult delegated representative functionality**, which is coming soon for integration with apps. This function allows an approved delegate to access another person’s account, with additional capabilities to support and manage multiple users sharing the same device on their own identity credentials.

- **Digital identity services** ensure people wanting access to health information via APIs are correctly identified before the relevant information is made available. In the last quarter, these additional identity services are now being used in 15 apps, including My Health Record (access to immunisation information), the Pacific Health Scholarship programme, and Tātai iwi affiliation data collection.

- The **National Events Management Service** team is working towards moving the service into production in March, notifying subscribers of death events. It will be available to the wider health sector, subject to usual onboarding requirements. From April 2024 it is planned to extend to topics other than death events, and onboard new subscribers to the death event.

- In a survey to help understand **FHIR training needs**, 74 percent of respondents said they already used FHIR products; 82 percent said they would be consuming or developing FHIR services in the next 18 months; 68 percent said they thought

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it was very important or extremely important that FHIR training was customised to address New Zealand-specific use cases and healthcare needs.

- Drafting of **standards and policies** to guide the digital health sector on the development of APIs is progressing well. A technical standards committee has been set up to provide feedback on API standards drafted by Health New Zealand, and reviewing of standards has begun. To date, two standards have been made available to review:

  - API Design and Development (FHIR and none FHIR)

  - API Security.

  Feedback received has been minor or clarifications, with no significant change

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Aide-Mémoire

Cleanliness of Hospitals

To:	Hon Dr Shane Reti, Minister of Health	Reference:	HNZ00040218
From:	Fionnagh Dougan, National Director Hospital and Specialist Services	Due Date:	20 March 2024
Copy to:		Security level:	In Confidence

Contact for telephone discussion (if required)			
Name	Position	Telephone	1st contact
Sally Dossor	Head of Office and Business Support, Hospital & Specialist Services	S 9(2)(a)	X
Fionnagh Dougan	National Director, Hospital and Specialist Services		

Attachments
Appendix 1: Patient Survey results regarding cleaning

Purpose

1. This aide-mémoire provides you with information regarding the standards that apply to the cleaning of hospitals, and the monitoring and audit processes in place to provide assurance that those standards and being met.

Background / context

2. A clean healthcare environment is essential to the safety, dignity and comfort of hospital staff, patients and visitors. Cleanliness in the healthcare environment is vital to preventing healthcare associated infections.
3. In December 2023, you were made aware of an issue regarding Auckland City Hospital: a poor consumer experience involving a dirty toilet. We provided information to you on 13 December 2023 (HNZ00033646 refers).
4. We noted in that advice a stocktake of cleaning audit standards across other hospital would take places, including a focus on the processes hospitals have in place to provide assurance they are maintaining such standards.
5. A concern has subsequently been raised by a member of the public about insects and ventilation at Whangārei Hospital. A ministerial response was sent to that person in March 2024.

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Discussion

Contracting

6. Hospital cleaning arrangements are a mix of inhouse and contracted cleaning services. Some districts have fully in-house services in their hospitals, some are completely outsourced, and some have a mix.
7. Contracts should and do specify clearly to all stakeholders, including cleaning staff expectations regarding the elements of applicable standards and auditing process and the consequences of not meeting contractual requirements.
8. Contracts provide the opportunity to specify our expectations regarding contractual performance through the scope of work, and reference to the relevant elements of applicable standards. Contracts also typically define auditing processes and the consequences of not meeting requirements. Prior to awarding a contract, the procurement process will assess the service provider's track record capacity and capability to perform.

Cleaning Standards

Health Certification

9. The Ministry of Health – Manatū Hauora administers the Health and Disability Services (Safety) Act 2001 (the Act). The Act requires providers of health services to be certified against the relevant standard: Ngā Paerewa Health and Disability Services Standard NZS 8134:2021.
10. NZS 8134:2021 Ngā Parewa Health and Disability Service Standard 5.5: Environment criterion 5.5.3 states:

    "Service Providers shall ensure that the environment is clean and there are safe and effective cleaning processes appropriate to the size and scope of the health and disability service that shall include:

    a) Methods frequency and materials used for cleaning processes;

    b) Cleaning processes that are monitored for effectiveness and audit, and feedback on performance is provided to the cleaning team;

    c) Access to designated auditors for the safe and hygienic storage of cleaning equipment and chemicals.

    "This shall be reflected in written policy."

11. Local infection prevention and control teams generally oversee that cleaning and cleaning audit standards are adhered to in hospitals.
12. Each area is independently audited three-yearly for compliance with the Standard. That audit may include reviewing the outcomes of hospital specific cleaning policies, procedures and audits.
13. All districts audited fully achieved this standard in 2022/23.

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Cleaning Specific Standard

14. Most hospitals across New Zealand currently adhere to cleaning standards aligned with the Victorian Standard set by the Australian Department of Health[1]. We use Australasian standards and Australian clinical guidelines, given our medical colleges are Australasian.
15. The Victorian Standard provides clear guidance for the delivery of cleaning services, regardless of the delivery model (outsourced, in house or mixed) and for monitoring and assurance processes It focuses on outcomes of the cleaning process, rather than processes or inputs.
16. Areas inside a hospital are audited against a set of elements split acros four major groups: buildings, fixtures, equipment and environment. (Note, toilets and bathrooms fall under 'fixtures').

Auditing process examples from hospitals

17. In Tairāwhiti, all areas within the hospital are audited against the Victorian Standard. Each audit is conducted against a set of elements split across 10 major groups: Hard floors, Carpet floors, High Dusting, Low Dusting, Furniture, Basins and sinks, showers/baths/toilets, glass and rubbish, supplies cleaning equipment. A duty ist checklist is also used for each cleaning staff person with clear instruc ions on what is required and is signed off by the service manager/charge nurse manager for that area.
18. In Rotorua Hospital, internal audits are carried out for services in all functional areas and reflect the elements of the Victorian Standard Audits are carried out weekly. If any audits fail to meet aspects of the Victorian Standard rectification must take place within a specified time period, depending on the r sk profile of the area
19. For Whanganui Hospital, which also uses the Victorian standard, this flowchart describes a typical audit process:

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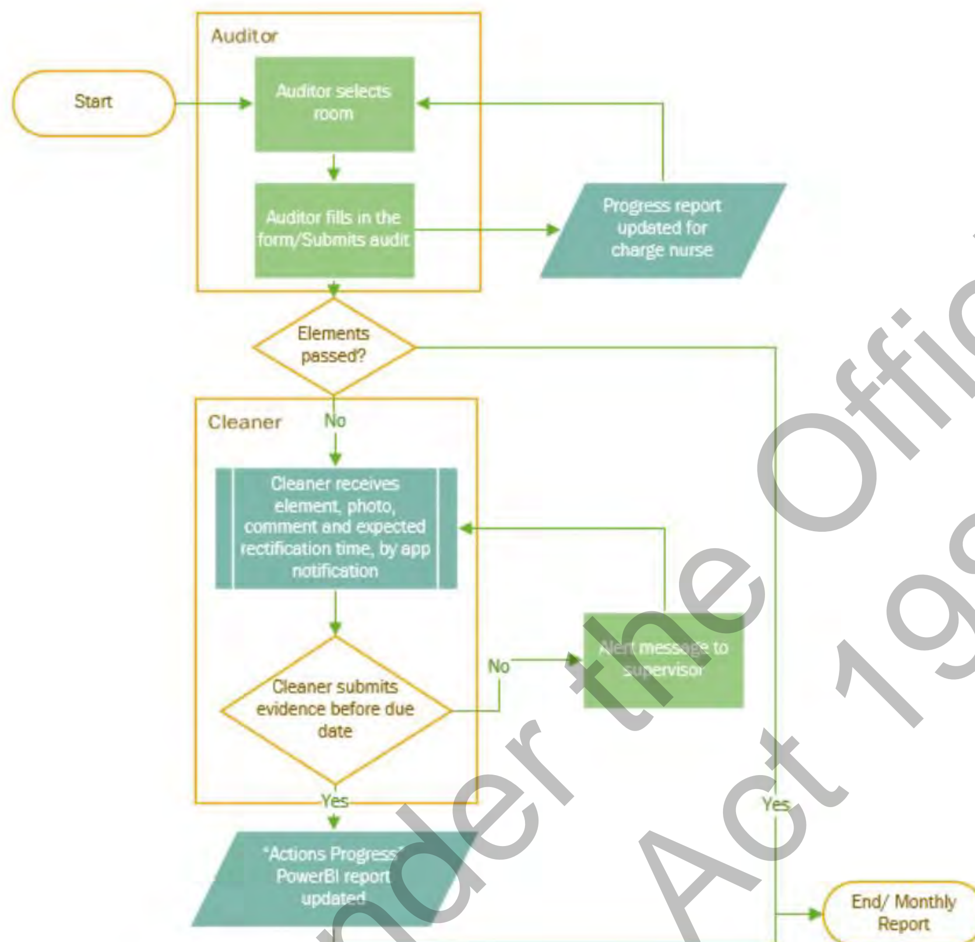
[1] Cleaning standards for Victorian health facilities 2011 (vgls.vic.gov.au)



20. Waikato (which has four hosp tals) undertakes three types of monitoring/auditing to the Victorian standard

    a. Visual and touch audit conducted by cleaners, minimum 500 completed per month.

    b. Joint audits between Health New Zealand – Te Whatu Ora staff and cleaners: one scheduled every Friday with Health New Zealand staff on a roster (includes contract manager Infection Prevention Control, Quality and Patient Safety and Nursing staff).

    c. Glo-bug auditing, ad-hoc, primarily used for performance management or outbreak management, it involves laying paste/powder invisible to the eye, and then using ultraviolet ligh to check if it is gone after cleaning.

21. If an audit is failed corrective actions including reporting are taken to clarify the reasons for a failed audit and for re-checking/re-auditing.

Other measures of cleanliness

Infection Prevention and Control

22. A hygienic environment plus hand hygiene are key infection, prevention and control measures to prevent cross-infection. The hand hygiene programme is hosted and monitored by the Health Quality and Safety Commission (HQSC).

23. Standard precautions, as described by the World Health Organisation, are designed to reduce the risk of transmission of bloodborne and other pathogens from both recognized and unrecognized sources. These are captured in New Zealand in infection prevention

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and control procedures. These procedures, while focused on measures to reduce transmission such as hand hygiene and PPE, also include reference to routine cleaning and disinfection of environmental and other frequently touched surfaces (linked to the Victorian Standard)[2].

Patient Experience Surveys

24. Patient feedback about health-related experiences and outcomes can help drive quality improvement to deliver better care and mitigate inequity across all levels of the health system.

25. The HQSC collects patient-reported measures through validated and standardised surveys which enable systematic collection, analysis and reporting. The HQSC Patient Experience survey contains questions on the Hospital Environment.

26. In November 2023, the results for the question "Were the hospital rooms or wards (including bathrooms) kept clean?" were mostly positive, with 81.3% of respondents replying "Yes, always", as shown below.

Survey question: Were the hospitals rooms or wards (including bathrooms) kept clean?

	Response %		
Ethnic Group	**Yes, always)**	**Sometimes**	**No**
All	81.3 (80.1-82.4)	15.9	2.9
Māori	75 (72-77.8)	21.2	3.8

27. Further results for November 2023 related to cleaning component of this survey are attached at Appendix 1.

28. As a comparator, a National Health Survey in the United Kingdom asks: "How clean was the hospital room or ward that you were in?" Most respondents between 2020-2022 provide a similar (if slightly less positive) response:

	Survey year (Count)			Survey year (%)			Significance	
	2020	2021	2022	2020	2021	2022	Significant change 2020-2022	Significant change 2021-2022
Very clean	54,915	44,683	42,994	77.1%	73.7%	70.3%	↓	↓
Fairly clean	14,522	14,084	15,945	20.4%	23.2%	26.1%	↑	↑
Not very clean	1,394	1,429	1,713	2.0%	2.4%	2.8%	↑	↑
Not at all clean	378	466	483	0.5%	0.8%	0.8%	↑	
Number of respondents	71,209	60,663	61,135	100.0%	100.0%	100.0%		

Next steps

29. We are happy to discuss this paper with you and provide further information if required.

[2] Precautions: standard and transmission-based | Te Tāhū Hauora Health Quality & Safety Commission (hqsc.govt.nz)

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Appendix 1: Patient Survey Results

The patient experience survey contains a range of questions on the Hospital Environment. The question on cleaning with responses for November 2023 at both a national and district level is below.

Survey information | Survey analysis | Relevant links

Survey information

Which patients are included

The survey sample includes patients aged 15 years and older who stayed for at least one night in hospital during the survey period, where the hospital stay ended with a routine discharge or self-discharge. It does not include patients who were admitted to a mental health service in the hospital, were transferred to another health facility or died in hospital. Approximately 3,000 patients take part each time.

How information is collected

Patients selected for surveying are contacted by email or SMS (text). Māori and Pacific patients are sent both an email and a text reminder where contact details are available to increase response rates for these population groups. Survey responses are anonymous unless patients choose to provide their contact details in their survey feedback. Contact information was provided by the Ministry of Health for the purpose of this survey only, and all identifiable information such as name and email address is deleted once the survey invitation period ends.

How long the survey lasts

The survey runs every three months (called a quarter; four in a year). Patients discharged within the same two-week period in each Te Whatu Ora health district. Due to their smaller size, some districts – Whanganui, Taranaki, South Canterbury and West Coast – choose to run the survey over a four-week period.

Results are displayed in a variety of ways.

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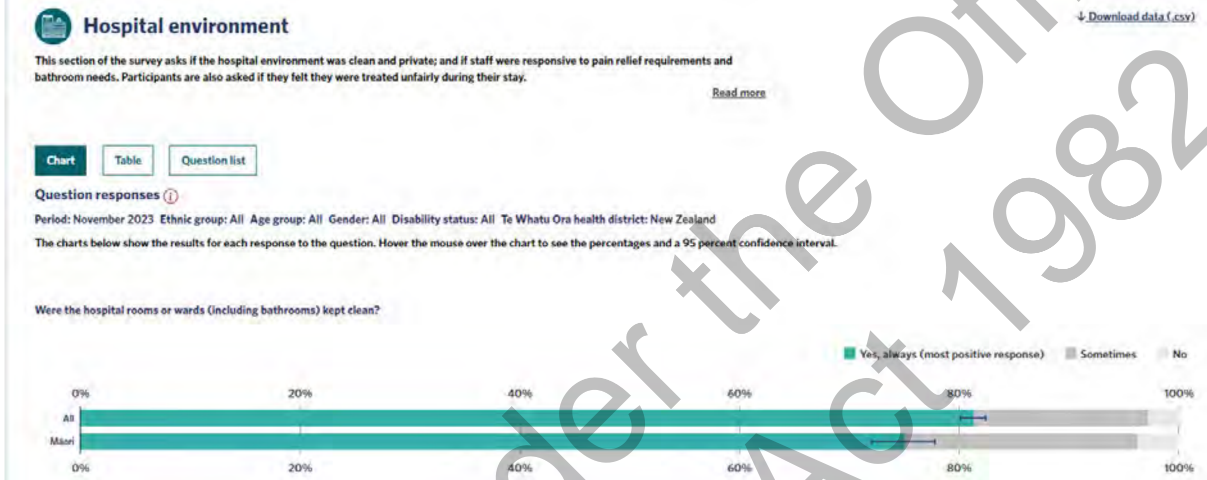

Broken down

Were the hospital rooms or wards (including bathrooms) kept clean?

	Response (%)		
Ethnic group	Yes, always (most positive response) (95% CI)	Sometimes	No
All	81.3 (80.1-82.4)	15.9	2.9
Māori	75 (72-77.8)	21.2	3.8

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Aide Memoire

HWIP December 2023 Workforce Data

To:	Hon Dr Shane Reti, Minister of Health	Reference:	HNZ00041342
From:	Andrew Slater, Chief People Officer	Due Date:	22 March 2024
Copy to:		Security level:	In Confidence

Contact for telephone discussion (if required)			
Name	Position	Telephone	1st contact
Andrew Slater	Chief People Officer	S 9(2)(a)	x

The following departments/agencies have been consulted
N.A

Attachments
Appendix 1: Health Workforce Information Programme December 2023 quarterly report

Purpose

The purpose of this Aide Memoire is to provide you with a copy of the latest Health Workforce Information Programme (HWIP) quarterly report, which is as of December 2023.

Background / context

The HWIP team in Health New Zealand | Te Whatu Ora collects and collates aggregated workforce data (including FTE, headcount, demographic, by-profession cuts), key HR metrics and vacancy data which is sourced from District Human Resource (HR) and payroll systems.

The HWIP dataset and reporting is a collaboration between Service Improvement & Innovation Health Analytics (Special Initiatives team); Data & Digital (Central Region Data Platforms); district payroll teams; and People & Communications.

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The HWIP programme has been in place since 2006. S 9(2)(g)(i)

Quarterly reports

The main product created by the HWIP team is the **Quarterly HWIP return.** This product has been produced each quarter since 2006, with comparable data from 2012, to ensure the health system has a consistent set of data on its local workforce. The quarterly reports are subject to significant validation by our HWIP teams.

This validation process includes:

- Extensive data quality and data completeness checks applied as the data is received and loaded into the database, including working with Districts,
- Draft quarterly report reviewed and assessed for consistency and comparability.
- Second round of validation by districts of the draft report
- approvals and sign-outs.

These quarterly reports are Health NZ's primary source of workforce data for responding in any official capacity to data queries including Written Parliamentary Questions, Oral Parliamentary Questions, and media requests.

Quarterly reports are proactively released on the Health New Zealand website found here Health workforce information programme – Health New Zealand | Te Whatu Ora. [1]

We also prepare operationally indicative snapshots into the workforce, such as by-profession snapshots into changes in FTE, vacancies, and sick leave rates. The Health Workforce Information Team also responds to hundreds of general enquiries each year. This reporting ensures the organisation can closely monitor any surges or changes in capacity and capability at a national level as well as locally.

HWIP December 2023 quarterly report

Appended to this paper is a copy of the latest HWIP quarterly return as of December 2023.

Overall, full-time equivalent (FTE) workforce figures show continued and sustained growth year-to-year, across the board.

The first chart shows that the total FTE reported at the end of each calendar year. Please note that FTE measures hours worked by each person as well as total headcount.

The 12 months to December 2023 have the largest increase in overall health workforce FTE numbers in the last six years, this is mostly as a result of significant growth in nursing numbers.

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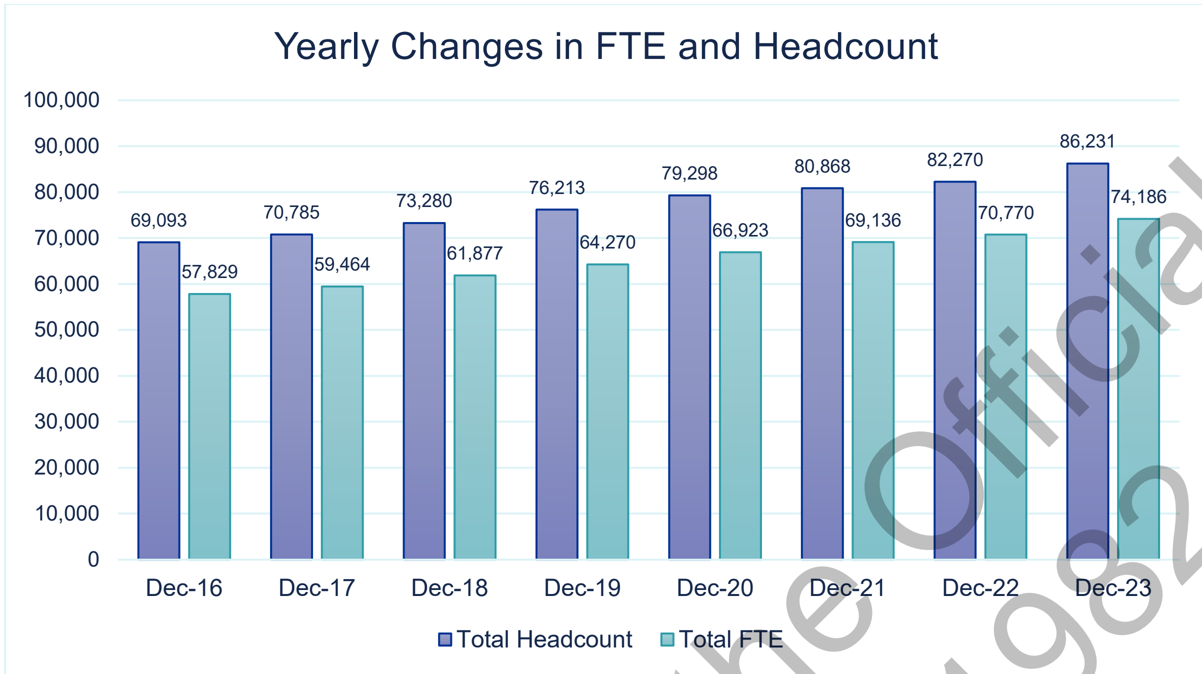
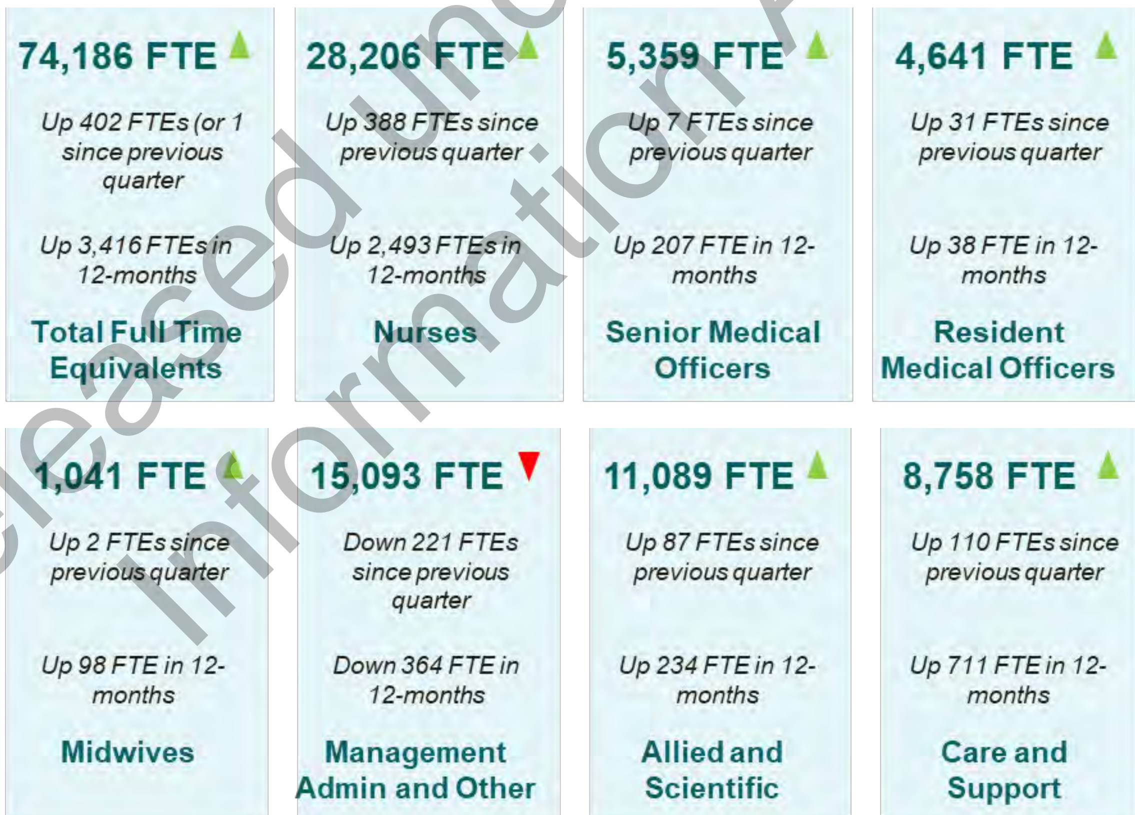
[1] https://www.tewhatuora.govt.nz/whats-happening/what-to-expect/for-the-health-workforce/health-workforce/health-workforce-information-programme/



We have provided you with some key snapshots of headline workforce figures below.

Te Whatu Ora employed workforces as at December 2023



Source: Health Workforce Information Programme quarterly reporting (HWIP)

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Key workforce groups

We have not noticed any substantial changes to the rankings of our key workforce groups. Nurses continue to be our largest profession by FTE, SMOs continue to be our longest serving workforce on average.

The proportion of the workforce who identity as Māori and Pacific remains steady, at around 8.7% (no change to the last quarter) and 5.1% (slight decrease since last quarter) respectively. A summary of the key datasets is provided for you below.

Total employees 86,231 in 87,663 positions* 67,342 female 18,835 male 55 Another/Not Stated Gender	74,186 FTE 56,797 FTE** females 17,339 FTE** males 49 FTE** Another/ Not Stated Gender	Largest HWIP occupation group: Nurses – 33,654 employees in 34,534 positions Smallest HWIP Occupation group: Midwives – 1,491 employees in 1,563 positions
District employee average age 44.6 years 44.7 years for females 44.5 years for males	Oldest male HWIP occupation group: SMO (mean age 51.4 years) Youngest male HWIP occupation group: RMO (mean age 31.7 years)	Oldest female HWIP occupation groups: Corporate and Other (mean age 49.9 years) Youngest female HWIP occupation group: RMO (mean age 31.4 years)
Mean FTE rate 0.86 per employee Mean FTE rate for females 0.84 Mean FTE rate for males 0.92	Longest Length of Service HWIP occupation group SMO (mean 10.3 years) Shortest Length of Service HWIP occupation group RMO (mean 1.6 years)	Employee reported ethnicities: Other*** – 57.2% Asian – 28.9% Māori – 8.7% Pacific – 5.1%

Source: Health Information Workforce Programme (HWIP)

Updates by professions

In the quarter between October and December 2023, Health NZ achieved several successes which are demonstrated in the changes in the headline workforce figures. We have provided you with some summary note setting out the key updates by profession.

Nursing

Health New Zealand | Te Whatu Ora increased funding for the Nurse Practitioner Training Programme in 2023 which resulted in 121 funded nurse practitioner trainees being accepted into the 2024 training programme, including 17 Māori nurses and 5 Pacific nurses. The increase compared to previous year was 51.3%.

At the end of January 2024, 2,450 Internationally Qualified Nurses (IQNs) who were required to complete a Competence Assessment Programme (CAP) had successfully received reimbursement through the Health New Zealand IQN CAP Support Fund since it started in August 2022.

Doctors

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Positive progress underway in the General Practice Education Programme (GPEP). Following the approval of budget for GPEP, we are supporting 239 GPEP 1 trainees through the programme in 2024, an increase of 60 additional registrars starting the Programme compared to 2023 and the biggest intake to date.

New Cardiac Sonography Course at University of Auckland. We are working on a joint announcement with the University of Auckland for the new Post Graduate Diploma in Cardiac Sonography that will commence March 2024.

Expanded the Rural Medical Immersion Programme (RMIP) at Otago University by 10 students and contracted the University of Auckland to establish a RMIP at Auckland University. This will be available for the 2025 cohort of Year 5 medical students. In addition, there are four interprofessional programmes running in rural, regional and harder-to-staff areas: Tairawhiti, Whakatane, Hokianga, and Te Waipounamu. These are currently five-week programmes to provide an interprofessional experience to undergraduate health students.

Midwifery

Midwifery Return to Practice – as part of the Workforce Plan, the midwife y return to practice fund was relaunched on 28 February 2024 to attract more midwives back into the profession. The funding available has been increased to reflect the actual costs incurred for the programme and it also offers additional support for transport, family care or other relevant miscellaneous costs up to a set limit. The increased funding will also be available to midwives currently on the programme with the aim to incentivise completion.

The Te Ara ō Hine-Tapu Ora initiative was in place which provided $6 million for liaison staff at midwifery schools to provide wrap around care and academic support to actively recruit Māori and Pacific students. In addition to this new function, Te Aka Whai Ora have also provided a small, targeted hardsh p fund for students experiencing significant need to access support.

Kaiāwhina

Health New Zealand has progressed implementation of the kaiāwhina cadet programme developed in Hawkes Bay. The programme has had significant success in the Hawkes Bay, creating an ntry pathway for careers in health. Implementation has commenced in Tairawhit with 11 cadets currently enrolled in the programme.

Our Comprehensive Prima y & Community Care Teams' initiative supported the expansion of other workforces into primary care. This includes the introduction of roles such as pharmacists, kaiāwhina, paramedics and care coordinators.

Allied and Scientific

Health New Zealand | Te Whatu Ora has been engaging with Hato Hone | St Johns to expand funding for earn-as-you-learn paramedicine pathways.

Work is underway to train an additional 60 pharmacy prescribers in 2024.

A new website was developed promoting allied health and scientific careers and launched at a conference of school careers advisors.

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Next steps

Health NZ will publish the appended quarterly report on its website on the week commencing 25 March 2024.

Lead Author: Mana Williams-Eade, Principal Advisor, Office of the Chief People Officer

Responsible Manager: Emily Richards, Head of the Office of the Chief People Officer.

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Aide-Mémoire

Follow up to your 19 February meeting with GenPro

To:	Hon Dr Shane Reti, Minister of Health	Reference:	HNZ00039093
From:	Abbe Anderson National Director Commissioning	Due Date:	21 March 2024
Copy to:		Security level:	In Confidence

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Martin Hefford	Director, Living Well, National Commissioning	S 9(2)(a)	x
Astuti Balram	Group Manager, Primary Care, Living Well, National Commissioning		

Attachments
Appendix 1: Cost and demand pressures in general practice over time

Purpose

1. This Aide-Mémoire provides you with information which you requested following the meeting with GenPro (the General Practice Owners Association of Aotearoa New Zealand) on 19 February to discuss the PHO Agreement Amendment Protocol (PSAAP), Annual Statement of Reasonable Fee Increases (ASRFI), Fee Review Committee process, options to support enrolment with primary care, representation, pharmacist immunisation, and the impact of telehealth.

Key Summary

2. The PHO Agreement Amendment Protocol (PSAAP) sets out the principles and approach that Health New Zealand | Te Whatu Ora (Health NZ) and PHOs will take to determine amendments to the PHO Services Agreement (PHOSA). The PSAAP process recommenced on 15 March 2024 and is expected to consider Health NZ's annual uplift offer at the May 2024 meeting.
3. The Annual Statement of Reasonable Fee Increase (ASRFI) is the contractually agreed process to quantify the annual cost pressures faced by general practice to inform both the annual uplift in capitation funding and the accepted increase in fees or co-payments.

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There are limitations with the ASFRI and while alternative methodologies have been developed, they have not been agreed to date.

4. Co-payments are an important component of the overall revenue for most general practices. For FY 2023/24, it is estimated that 26% of general practice funding is related to co-payments. The fee review process is set out in the PHOSA, Fees Framework (clause F.22). PHOs must notify Health NZ of all increases in fees charged for standard GP consultations.

5. S 9(2)(f)(iv)

6. Health NZ is developing a bundle of initiatives to improve newborn enrolment rates, with expected flow-on positive impacts on both immunisation rates and general engagement with primary care. These include a Newborn Enrolment Service Integration (NBESI) revision of the PHOSA business rules for pre-enrolment for newborns designing a six-week check bundle for general practice teams and requesting a varia ion to the PHOSA to make it a requirement to enrol the baby of an enrolled parent.

General Practice – Contract Negotiation, Fees – Uplifts and Reviews

The PHO Services Agreement and PHO Agreement Amendment Protocol

7. The PHO Services Agreement (PHOSA) sets out the common contractual terms between Health NZ and PHOs. It is reflected in compulsory back-to-back agreements between PHOs and contracted providers. It defines the prices for many services (including capitation), and business rules and requirements that govern fee setting, subcontracting reporting, enrolment rules and other matters.

8. The PHO Agreement Amendment Protocol (PSAAP) sets out the principles and approach that Health NZ and PHOs will take to determine amendments to the PHOSA. If the parties cannot reach agreement on a voluntary variation, then the PHO agreement makes provision for compulsory variations *"in order to give effect to any Crown Direction, law change, or payment rate increase ..."*.

9. The PSAAP group has been in abeyance since June 2022 when the contracted provider representat ves withdrew from the PSAAP negotiation process due to their unhappiness with the proposed annual uplift in capitation. Since this time, annual uplifts have been issued by Health NZ as compulsory variations to the PHOSA. Other changes to update the PHOSA in line with new service delivery have not been possible and alternative contracts have had to be executed.

10. The PSAAP process recommenced on 15 March 2024 and will continue on a regular basis. The May 2024 meeting is expected to consider Health NZ's annual uplift offer.

The Annual Statement of Reasonable Fee Increase

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Origin of the ARFI

11. When capitation was introduced, GPs agreed to reflect the additional funding by reducing co-payments, and the Government signalled its intention to maintain the real value of capitation over time. The ASRFI is the contractually agreed process to quantify the annual cost pressures faced by general practice to inform both the annual uplift in capitation funding and the accepted increase in fees.

12. The ASRFI has a clearly prescribed and agreed methodology from which there is little room to deviate. It therefore brings a degree of transparency to decisions about annual adjustments to capitation and co-payments. Results are independently calculated and use the following Statistics New Zealand indices for the year to 31 December to determine the increase to apply from 1 July the following year:

    a) Labour Cost Index (LCI): Health Care and Social Assistance (this determines 80% of the cost calculation)

    b) Producer's Price Index (PPI): Inputs – Health Care and Social Assistance

    c) Capital Goods Price Index (CGPI): Non-Resident Buildings

    d) Capital Goods Price Index (CGPI): Plant, Mach nery and Equipment.

13. The ASRFI methodology was developed because no single index, including the Consumer Price Index (CPI), was considered an appropriate measure (the CPI, for example, includes other items that are not relevant to the costs of running a general practice).

Alternative methodologies considered

14. Heath NZ acknowledges the limitations of the ASRFI methodology as an input for annual uplifts and as a mechanism for regulating co-payment fees.

    a) It is based on backward- ooking cost indices, so general practice owners see price increase at least a year after they occur across the rest of the sector.

    b) It is well adapted o passing on smooth, continuous changes to prices that occur over the medium-term, but is not well adapted to incorporating sudden price shocks such as that caused by increases to the then Health NZ employed nurse Mu ti Employer Collective Agreements (MECA).

    c) It has been in place for 20 years and there has been little analysis of the impact it has on the affordability of general practice services, and what this looks like for people in different communities and regional economies.

    d) It does not measu e changes in complexity associated with the increase in the population aged 80+, or those associated with increasing survival rates from long-term conditions, or the increase in disease associated with obesity such as diabetes.

    e) It also does not recognise increases to the clinical expectations of general practice. For instance, 20 years ago most cases of diabetes were managed through outpatients but most are now managed in primary care. Similarly, there has been a shift in expectations of primary care work-up pre-referral and follow-up post specialist intervention.

    f) Given that most general practice co-payment fee reviews result in agreement to increase fees, this suggests that the ASRFI mechanism is not effectively capturing cost increases for general practice.

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15. In 2019/20 the ASRFI methodology was reviewed by a working group comprising representatives from primary care, the former district health boards and the Ministry of Health. A range of options were considered around the calculation including:
    a) Construction of a bespoke cost index to improve representativeness of data;
    b) Introducing a forecasting element to reduce time lags;
    c) Using Ministry-collected DHB financial data to improve both timing and representativeness of data;
    d) Using cost data from negotiated MECA to improve the representativeness of data.
16. The group made two recommendations to alter the methodology:
    a) Increasing to the weighting of LCI relative to other costs; and
    b) Using cost data from relevant secondary care MECA as a comparator.
17. In response to these recommendations, the LCI weighting has increased from 70% to 80% within the calculation, with PPI and CGPI weighting reducing slightly. Da a from the relevant MECA is also included as a comparator to LCI when the annual statement is prepared.
18. In 2022, GenPro presented an alternative general practice cost pressure assessment that it believed addressed many of the ‘flaws from the current methodology to the PSAAP Group. The alternative was based on cost sampling rom a selected group of practices. GenPro recommended that its alternative methodology should be used until such time that the findings of the Sapere review were implemented. This proposal was not supported by the district health board and Ministry of Health representatives at the time on the basis that the proposed method was not independently verified or statistically robust.
19. In 2022, the Sapere review of capitation was completed and indicated a shortfall of $137 million a year to meet the cost of current GP team activity. This level of uplift is yet to be considered and applied. Of note, in 2024 this shortfall was revised to $173 million to account for subsequent cost and rev nue changes.

General practice fees reviews

20. Co-payments are an important component of the overall revenue for most general pract ces. For FY 2023/24, it is estimated that 26% of general practice funding, equivalent to $482 million, is related to fees/co-payments.
21. The PHOSA has a mechanism for a Fees Review Process to ensure that fee increases for a standard consultation during the day remain fair and reasonable to both patients and providers.
22. The fee review process is set out in the PHOSA, Fees Framework (clause F.22). PHOs must notify Health NZ of all increases in fees charged to enrolled people by contracted providers for standard GP consultations. If Health NZ is notified of a fee increase that is greater than a reasonable level, compared with the ASRFI, it may, within one month, refer the increased fees for review by a Regional Fees Review Committee (RFRC).
23. Health NZ regional commissioning teams will decide whether to refer fee increases to the RFRC, through discussion with the PHO, considering (per the relevant contract clauses):

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a) The affordability of the increased fees for the provider's enrolled population;

b) The availability of other local providers, and a comparison with the fees they charge;

c) The extent to which the fee increase is necessary to maintain or improve the capacity of the provider to meet the needs of its enrolled population.

24. Between July 2022 and September 2023, there were 58 referrals to RFRCs, of which:

a) For 49 referrals the Review Committee recommended that the increased fees were fair and reasonable

b) For five referrals the Review Committee did not recommend the ncreased fees

c) For four referrals the fee increase was withdrawn before the Review Committee made a recommendation.

ASRFI & Uplift - Impact on co-payment fees

25. One important property of the ASRFI is that it makes exp cit the relationship between cost increases faced by practices, annual capitation funding adjustments and co-payment increases.

26. In years when capitation increases by less than the price growth calculated by the ASRFI, allowable co-payment increases must be greater than that average price increase to compensate costs of running general practices. A summary of the cost and demand pressures in general practice over time is included in Appendix 1.

27. Where co-payment is fixed at a relatively low absolute eve (for all patients enrolled in VLCA practices and for patients holding Community Ser ices Cards (CSC) in other practices), then a below-inflation increase in capitation means that practices have few options for finding other revenue to address cost increases. VLCA practices, many of which serve the highest need populations in New Zealand, have no ability to seek fees review or to increase fees for a subset of their overall population. Non-VLCA practices have the option of increasing co-payments for patients who do not hold a CSC and will face a disproportionate share of any cost increases.

28. Overall, the mechanism for co-payment regulation that has been in place for two decades no longer has the confidence of the sector. The two main regulatory tools of ASRFI and fees review show limited effectiveness.

29. As a principle, changes to co payment regulation should be considered as part of the overall picture of general practice funding, and settings should take into account any other changes to general practice funding mechanisms.

S 9(2)(f)(iv), S 9(2)(j)

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S 9(2)(f)(iv), S 9(2)(j)

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General Practice –Enrolment support

36. As of February 2024, 4,983,487 people were enrolled with general practices in New Zealand. However, around 250,000 people are known to not be enrolled, of whom 15% are Māori, 12% Pacific, 36% European, 26% Asian and 10% other ethnicities. Those not enrolled are more likely to suffer avoidable morbidity and mortality.

37. Around 57,000 babies a year are born in New Zealand. As of February 2024, 49,049 “0” year olds were enrolled with general practices. Timely enrolment is critical to improved outcomes for children and whānau, including through immunisation.
38. Childhood immunisation rates in New Zealand have historically been below the required 95% target for immunisation coverage.

Enrolment of Newborns

39. The National Enrolment Service (NES) was developed in partnership with the primary care sector and is embedded within the PHO Services Agreement (PHOSA).
40. The NES provides the single source of the recorded truth about a person enrolled with a general practice. Population level data provided by NES underpins capitation based funding and volume data analysis (GPQED) for the health system.
41. There is variation in newborn enrolment approaches, which has led to significant and enduring delays in enrolment for newborns. (Refer Figure 1).

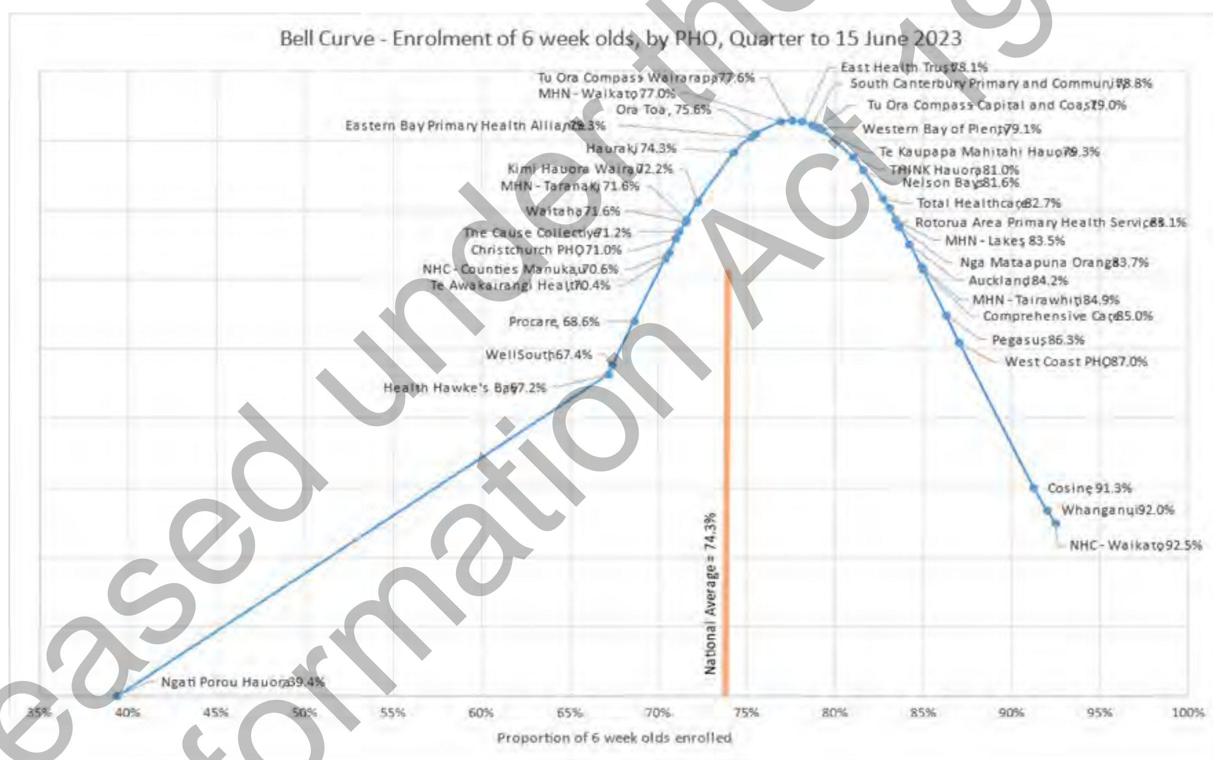

Figure 1 Newborn Enrolment, by PHO, September 2023

42. Delays in newborn enrolment impact on childhood immunisations, Well Child Tamariki Ora services and crucial engagement with and access to primary care, including often for the benefit of mothers and a newborn’s whānau.
43. Health NZ is developing a bundle of initiatives to improve newborn enrolment rates, with expected positive flow-on impacts on both immunisation rates and access to primary care. The package will likely include the following:

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a) A Newborn Enrolment Service Integration (NBESI) programme that seeks to significantly automate newborn enrolment processes to remove some delays and errors;

b) Revision of the PHOSA business rules for pre-enrolment for newborns. Currently a practice may provisionally enrol a newborn, prior to the full enrolment process being completed. However provisional enrolment remains valid for only three months and there is a significant drop off at the three-month period where the caregivers have not yet completed the paperwork to fully enrol the newborn. There are likely to be benefits from extending this provisional period to at least six months to enable the crucial engagement for immunisation to be completed and for the wider six week health checks to be completed;

S 9(2)(f)(iv)

Other issues raised by GenPro

Community pharmacies delivering immunisations

45. In April 2023, the National Immunisation Taskforce publi hed a report that identified 10 priority areas and made 54 recommendations to increase immunisation coverage in New Zealand. The report highlighted that one barrier is access to vaccinators.

46. Community pharmacies across New Zealand provide another option for vaccination in the community. Pharmacies typically operate with longer opening hours and during weekends and can fac litate walk-in vaccinations. Appointments may be bookable through BookMyVaccine or directly through the pharmacy.

47. Childhood immunisations have recently been enabled through community pharmacies in accordance with the New Zealand National Immunisation Schedule, and pharmacist vaccinators will be upskilled to become authorised vaccinators enabling whole-of-life vaccine administration.

48. Health NZ is scop ng an option for pharmacists to be funded to actively refer unenrolled children to a general practice for enrolment.

Telehealth

49. Telehealth provides an alternative mechanism to access care in the community.

50. For people who live in areas with fewer doctors, telehealth enables care to be provided by clinicians based elsewhere. Telehealth also provides options for additional capacity outside of usual opening hours of general practice.

51. For clinicians, telehealth can be a means to retain their skills. Some clinicians are willing to work post-retirement or to extend hours while juggling family responsibilities because

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telehealth consultations can be provided from home at all hours. There is generally less follow-up clinical administration.

52. There is no currently available research on the net impact on the workforce and demand in non-telehealth general practices. There is also no evidence to confirm that telehealth providers, that sit outside of general practice, are drawing significant workforce resources from general practice.

Next steps

53. We would welcome the opportunity to discuss the options for managing this year's annual uplift and ensuring the sustainability of general practice.

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Appendix 1

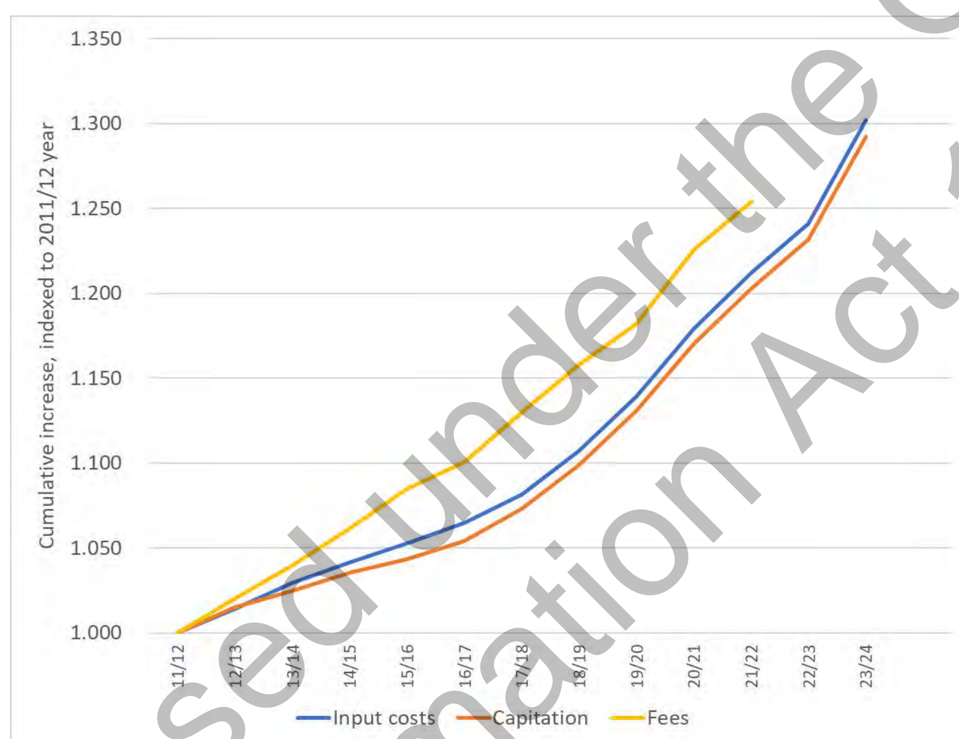
Cost and demand pressures in general practice over time

54. The graph below shows, indexed to the 2011/12 year, the:

   a) Cumulative increase in input costs for general practice, as estimated by the ASRFI;

   b) Cumulative annual increase in capitation rates;

   c) Cumulative increase in co-payments (weighted mean of adult co-payments in non-VLCA practices and for non-CSC holders).



55. There was a divergence between input cost and capitation increase in 2013/14 that widened in subsequent years. Since 2017/18 capitation increases have followed ASRFI costs but have not closed the gap that opened earlier, leaving an ongoing cumulative gap in funding. This is without considering additional cost pressures from MECA changes, increased complexity and the needs of those aged over 80 years.

56. Co-payments increased more quickly than input costs in the years before 2016/17, but since then increased at similar rates until 2021/22. More recent co-payment data is not stored in the same form and is not directly comparable, so is not included here.

57. It is expected that co-payments will increase more quickly than capitation at times when capitation increases by less than the ASRFI, particularly since the introduction of the CSC scheme, because a smaller pool of patients without fixed co-payments are

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the revenue source for making up the difference between cost increase and capitation increase.

58. Not shown is the CPI increase over this period as it is not directly relevant. However, the CPI changes over the same period have been similar to the ASRFI cost index changes, at about a 25% increase.

59. As noted, the capitation formula and ASRFI mechanism essentially apply to the service mix and cost structure of general practice as it was two decades ago. External changes over time such as increased presenting complexity, greater prevalence of mental health need and workforce pressures bring real costs to general practice in the form of a need for longer consultations/lower throughput, or costly recruiting processes. These cost pressures are not reflected in existing general practice funding mechanisms.

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Aide-Mémoire

Response to OAG Audit of Health NZ for the Year Ended 30 June 2023

To:	**Hon Dr Shane Reti, Minister of Health**	Reference:	**HNZ00040306**
From:	Rosalie Percival, Chief Financial Officer	Due Date:	22 March 2024
Copy to:		Security level:	In Confidence

Contact for telephone discussion (if required)			
Name	**Position**	**Telephone**	**1st contact**
Rosalie Percival	Chief Financial Officer	S 9(2)(a)	x
Peter Alsop	Chief of Staff		

The following departments/agencies have been consulted
N/A

Attachments
Appendix 1: Health NZ response to OAG matters raised

Purpose

1. This Aide-Mémoire responds to your request for information regarding matters raised in the *OAG Te Whatu Ora - Health New Zealand: Audit for The Year Ended 30 June 2023* letter, particularly around actions occurring to address issues raised and wider organisational risks.

Key Summary

2. Health New Zealand | Te Whatu Ora (Health NZ) has identified actions that have either been completed or are agreed to occur to address the matters raised by the Office of the Auditor-General (OAG).
3. Progress of these actions will be independently tracked and monitored by our internal Audit and Assurance function and reported monthly to the Chief Executive and bi-monthly to our Board's Finance and Audit Committee.
4. Most actions are expected to be completed by June 2024.

Background / context

5. OAG's first audit of Health NZ resulted in a non-standard audit report being issued. This was for two reasons:
   i) It included a modified opinion on one aspect of the performance information: cardiac surgery waiting times. Two former districts did not maintain records to enable verification of the reported data.

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ii) It included an 'emphasis of matter' relating to the budget figures included in the financial statements. Health NZ was required to compare actual results to forecast financial statements prepared at the start of the financial year. However, Health NZ compared its results to forecasts published on 23/6/23, a week prior to year-end.

6. The audit report otherwise identifies control improvements and includes an unmodified opinion on the financial statements of Health NZ.

Discussion

How we are responding to the modified opinion and emphasis of matter

Performance information - cardiac surgery waiting times

7. Historically, the Ministry of Health did not maintain a centralised database on whether cardiac surgery patients had received treatment within their recommended timeframes. Data was collated from systems (e.g. the patient management system, theatre lists, individual cardiac reports) and reported by individual district health boards for internal use.
8. Further complicating the ability to verify data, each district had different methods of recording their respective waiting list data. Two districts advised that certain aspects of collating cardiac data were not within a database that could be recalled, as the source where data is held is refreshed on a regular basis, removing previous information used to provide earlier data. Data may have been able to be verified by accessing individual patient records. However, this was not considered to be reasonably practicable within OAG audit timeframes.
9. We have now established the National Cardiac Network. The work plan for this Network includes collecting data on cardiac surgery and cardiology and ascertaining the appropriate method of collating meaningful KPIs electronically.
10. For FY2024, we are proposing to change the metric (via the Supplementary Estimates process) to 'The percentage of patients (both acute and elective) who are waiting for treatment beyond 120 days'. This measure can be verified by data extracted from the National Minimum Dataset in National Collections, which records when a patient is waitlisted and discharged.

'Emphasis of matter' relating to the budget figures

11. This issue arose due to the timing of completion of the Statement of Performance Expectation (SPE) and significant additional funding (primarily for COVID-19) being announced after the budgets had been completed. The reporting was against the later approved budget as variances would have been significant and confusing to the reader of the Annual Report. This is not an issue for 2023/24 as the funding and expenditure changes post approval of the 2023/24 SPE are not significant and will be explained as variances. The 2023/24 actual results will be reported against the approved SPE budget.

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Progress on each of the 'Other significant issues' raised in both the letter and attachment

Provision for remediation of holidays pay entitlement

12. The Holidays Act Remediation Programme is addressing incorrect leave payments to current and former employees, dating back to 1 May 2010. The complexities of the Holidays Act, the hours our people work and the employment arrangements in place, as well as the state of our payroll systems and processes, make this a very challenging programme of work. Each payroll we inherited was set up differently with different practices and local arrangements in place, and none of them complied with the Holidays Act.
13. Rectification and remediation payments were completed for current employees across our seven payrolls in the Auckland region in 2023. Project teams around the rest of the country are working to remediate our employees on the 17 remaining payrolls.
14. Each payroll will remediate current employees first, then former employees. Our aim is that remediation for all current employees will be completed in 2024. Payments to former employees will start in 2024 with Auckland and other payrolls. The plan is for all payrolls to make required payments to former employees by mid-2025 at the latest. However, it is likely that there will be a residual group of former employees not remediated due to potential difficulties in tracing people.
15. We will also then have to carry out work relating to employees who have transferred between payrolls since July 2022, to ensure any corrections are carried through for their complete period of employment with Health NZ as a single entity.
16. Planning for 2024 has involved sequencing the resources and support needed across the different payrolls, both from local payroll teams and from the external teams providing specialist support and assurance. A rigorous series of checks, testing and external assurance is completed before payments are made, and the system must be rectified. Ongoing attention will be needed to maintain compliance with the Holidays Act post-remediation.

Control environment and other matters

17. Appendix 1 sets out our responses (which have already been provided to the OAG) to each of the matters raised by the OAG in its letter to you (and the attachment). This includes how we have addressed or are addressing the environment, system, and control issues raised.

Our top organisational risks and how they are being managed

18. We report a set of Strategic and Enterprise Risks to the Board and in our Quarterly Performance Report to you (the 2023/24 Q2 report was submitted to your office last week – HNZ HNZ00038361 refers).
19. Each Strategic and Enterprise risk is assigned to an Executive Leadership Team (ELT) owner to progress mitigations. High-level mitigations are updated quarterly and included in reporting to the Finance and Audit Committee and Board.
20. In addition, to date, ELT have presented risk deep dives to Board Committees on 12 out of 15 of the Strategic and Enterprise Risks. A deep dive on Trust and Confidence has been developed and will be presented to the next meeting of our Finance and Audit

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Committee. The remaining two risk deep dive areas (Māori Health Aspiration and Equitable Health Outcomes) will be developed once we have finalised our framework on how we will give effect to Te Tiriti principles.

Next steps

21. Actions will be included in our internal Audit and Assurance monitoring processes to ensure they are appropriately addressed within the projected timeframes.
22. Progress will be monitored by our Chief Executive and the Board's Finance and Audit Committee.

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Appendix 1: Health NZ response to OAG matters raised

The following provides responses to the 'other significant matters' raised in the OAG audit of Health NZ for FY2023, as listed in the 'attachment' within the letter dated 9/2/24 to the Minister.

Item	Health NZ Response

Procurement, commissioning and contract management
1. *This is an area of significance for the organisation, and indeed for the health sector as a whole. Health NZ is highly reliant on private, community, and third-party providers for the provision of health services and also for the support of its own corporate functions. It is also an area of significant complexity, reflecting that the previous 20 DHBs had different approaches to procurement and commissioning.*
2. *The formation of Health NZ provides an opportunity to leverage its buying power. Health NZ has already noted issues including multiple contracts with the same provider, inconsistent pricing and short-term procurement arrangements. A multi-year change process is underway to address these issues.*
3. *At the time of our assessment of Health NZ's overall procurement, commissioning and contract management arrangements, significant elements of the required work on procurement and commissioning were underway. We would expect to continue to see progress including:*
– *Drafting and approving a procurement policy (or policies) to cover all procurement and commissioning activity.*
– *Drafting and approving a contract management policy (or include this above) that covers all contract management activity, including both commercial contracts and commissioned services.*
– *Reviewing all other policies related to procurement, commissioning and contract management to ensure they are fit for purpose and provide the required direction for staff, including on integrity and ethical issues.*
– *Compiling information on the overall pattern of procurement and contracting to inform and enable a more strategic approach than was possible under the previous multiple organisations.*
– *Ensuring delivery of a Procurement and Supply Chain strategy.*
– *Planning a structured approach to benefits realisation.*
	The Procurement and Supply Chain team in Hospital and Specialist Services (HSS) is drafting organisation-wide procurement policies. These policies, which will be ready by the end of June 2024, will not prevent different functions from developing their own contracting and procurement approaches. However, these approaches will need to be consistent with the organisation-wide policy. There will likely be policies related to integrity and ethical issues, financial control and the broader outcomes Health NZ aims to leverage through its spend.
	The National Contracting and Procurement Team (based in Commissioning) will develop a workplan by June 2024 to establish nationally-consistent contracting and procurement policies, guidance, systems and processes for commissioned services. These will, as above, align with the organisation-wide policies and will ensure nationally consistent processes for:
	▪ developing and managing service agreements, including Service Level Agreements (or alternative arrangements) with districts and other government agencies
	▪ developing (or adapting) templates and guidance for contracting and procurement
	▪ providing coaching, training and support to staff
	▪ capturing the benefits of contracting and procurement processes (in line with benefits measurement across Health NZ)
	▪ reviewing contracts to:
	  ▪ identify providers who have multiple contracts and determine if consolidation or alternative contracting arrangements will lead to better outcomes
	  ▪ determine the current duration of contracts and develop guidance on terms, with longer-term contracts encouraged where possible
	  ▪ identify how many contracts are paid in draft and provide support to significantly reduce this
	  ▪ work with Finance teams to identify inconsistent pricing across contracts and develop options and guidance related to this

Health Sector Agreements and Payments Systems 4. *The Health Sector Agreements and Payments (HSAAP) systems enable the management of contracts with third-party service providers. These systems process 120 million claims and $13 billion in payments annually for Health NZ and on behalf of other entities such as Te Aka Whai Ora – Māori Health Authority, the Ministry of Health, and Whaikaha – the Ministry of Disabled People.* 5. *Some systems are obsolete and increasingly unstable. They sit on infrastructure that is no longer supported by the vendors; rely on manual controls and the knowledge of key staff and supporting contractors; and the honesty of providers in the sector to provide accurate information.* 6. *We have been highlighting these risks to the Ministry of Health for a number of years (given its previous responsibility for HSAAP). A programme of work commenced in July 2021 to transform these systems so they would be capable of supporting the health sector reforms and to mitigate the growing risk of failure of the current systems.* 7. *We will continue to monitor progress as part of our future audits.*	In Budget 2021, Cabinet provided tagged contingency funding of $137.991 million over five years for the Ministry of Health (subsequently Health NZ) to transform the HSAAP systems. Joint Ministers have approved drawdowns for three tranches of the HSAAP programme. The entire contingency has been drawn down, including a total of $21.185 million in baseline funding to continue work on unfinished HSAAP systems and upgrade a range of connected systems. This will enable these systems to support the health sector reforms and mitigate the risk of them failing. In February 2023, a full Treasury Gateway review of the programme resulted in a 'Delivery Confidence' rating of Amber. This rating was upgraded to Amber-Green following an interim Assurance of Action Plan in May 2023, with all projected benefits expected to be realised with delays. These delays can be attributed, in part, to Health NZ staff, sector commissioners and provider organisations being at or near their capacity to successfully absorb more operational change. A Gateway review commencing on 18/3/24 will provide an up-to-date rating of the programme. Health NZ's internal assessment indicates a current rating of Amber-Red (due primarily to the impact of cost pressures on the programme schedule). The expectation is for full delivery, although the timeframe is expected to exceed the delivery forecast in the business case. Funding is forecast to be sufficient for the longer delivery period, although careful fiscal management will be required to balance the management of legacy system risks with upgrading additional systems that support HSAAP within the budget constraint.

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Item	Health NZ Response
Asset management 8. *Health NZ relies on a significant asset portfolio to deliver health services across the country.* 9. *We considered Health NZ's asset management arrangements, focussing on the Infrastructure and Investment Group (IIG) which has responsibility for facilities infrastructure.* 10. *While there is evidence of progress, in our view, it will be important for Health NZ to focus on:* – *documenting comprehensive asset management plans;* – *maintaining comprehensive, up to date asset condition and performance information to support optimal lifecycle asset management planning; and* – *defining clear service levels supported or delivered by the assets and undertaking regular monitoring and reporting against these service levels.*	The recommended focus areas have all been included in the IIG work programme. Work is occurring to align to both the International Infrastructure Management Manual (IIMM) and ISO 55000 (an international standard covering the management of assets). Asset Management Plans will be developed as part of building a national Asset Management Information System (AMIS) and baseline asset condition and performance information. This process is not yet automated, which is a rate-limiting factor in making timely progress. Internal business cases have been developed for these, but funding for both is still to be determined. In the meantime, local approaches will be retained. The timing of this investment will determine how quickly Health NZ can mature its asset management capability. Integration between AMIS and FPIM (Finance, Procurement and Information Management system) to update useful lives will be implemented as the baseline condition assessments of the estate are received. We expect the entire baselining of the estate to take up to five years. Regular monitoring and reporting of maturity journey and the condition and performance of assets is also not able to be undertaken without the baseline data and systems to support. Levels of service are being developed that are objective, auditable and provide measures and a target. This will enable assessment of where the gaps lie and where investment needs to be prioritised. This is dependent on the availability of baseline data and systems.
Valuation of buildings 11. *Health facilities are key to service delivery. Understanding their condition is therefore a key input into effective planning and budgeting. Health NZ owns a large portfolio of buildings with a carrying value of $9.0 billion at 30 June 2023.* 12. *We were satisfied that the value of buildings presented in the financial statements is reasonable.* 13. *We recommended that issues relating to weathertightness, seismic strength, asbestos and/or other contamination should be considered across the entire portfolio of Health NZ's building assets and dealt with consistently and appropriately in 2023/24 valuations.* 14. *We found impairment assessments and impairment testing were completed and documented inconsistently by Health NZ. We were satisfied that any impairment losses would be immaterial to our overall opinion, but note that relevant accounting standards require consistent assessments to be undertaken.*	Health NZ is working through the seismic work programme, which will provide more (though not complete) information on seismic risk. Asbestos management plans are also in place. Health NZ has limited knowledge of weathertightness or contamination issues. Business cases for the gathering of information and system requirements have been developed but require funding decisions. Once funding is approved, the implementation is programmed to take five years. Health NZ will address the consistency of identifying and documenting the impairment assessments in FY2024 year-end preparation instructions to all components (to be completed by mid-June). This will include assessment of Intangible asset work in progress.
Financial information systems and controls 15. *The continued operation of the system of internal control during any period of change is important to provide assurance about the reliability of financial and service performance information, both for decision making and annual reporting purposes.* 16. *The transition from the previous entities and functions to Health NZ would have put core systems, processes, and control activities under strain and it was therefore possible that controls may not have continued to be effective to mitigate the risk of fraud and error through this period of change.* 17. *We did not identify deficiencies in the system of internal control significant to forming our opinion.* 18. *We also concluded that all General information technology controls (GITCs) were designed and implemented appropriately and were operationally effective for the period under review. However, we note that the former districts are still running their own individual payroll and clinical systems and their own network infrastructure. Specific recommendations for improvement to GITCs are listed under 'Financial Information Systems and Controls' below.*	Health NZ's responses to items raised for 'Financial Information Systems and Controls' are provided below, see items 20.5 – 20.7.
Environment, systems, and controls for measuring financial and service performance	Individual responses are provided below, see items 20.1 – 20.12.

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Item	Health NZ Response
19. *Our conclusions on the management control environment, systems, and controls for measuring financial and service performance for Health NZ, for the year ended 30 June 2022/23, are set out in the table below.* 20. *We made our conclusions in the context of our work in forming an opinion on the financial and performance statements. The purpose of commenting on the underlying environment, systems, and controls is to highlight areas for improvement we identified during our audit. The grades assigned for 2022/23 are based on the accountability documents relating to that year. They are not an assessment of overall management performance, or of the effectiveness of Health NZ in achieving its financial and service performance objectives. (For an explanation of the grading scale and underlying scope please see Assessing and grading systems and controls — Office of the Auditor-General New Zealand (oag.parliament.nz))*	
20.1 Management control environment (Needs Improvement) *We understand none of the sub-committees of the Board are reviewing the service performance of Health NZ against the targets that have been set. It would seem appropriate for the Finance and Audit Committee (FAC) to regularly review the service performance information.*	Reports on service performance are currently considered by several parties: functional leadership teams, the Operational Performance Committee of ELT, ELT as a whole, Board committees and the Board. This includes consideration of various reports and artefacts, including monthly and quarterly reports that are also provided to the Ministry of Health and Minister as part of our formal accountability arrangements. Additionally, Health NZ has worked with the Ministry to develop a monitoring framework, which includes wider monitoring of the work that we do. Performance will always need to be considered by multiple groups across management and governance domains. However, Health NZ will consider whether it can strengthen flow, cadence and coherence across different groups to ensure that, together, there are strong arrangements in place to monitor and drive performance improvement through management accountabilities. The Board discussed this recommendation when it considered the Q2 report in February 2024. It has asked for more detail on timeframes for the flow of such reporting information (taking into account data availability timeframes) and impacts on publication deadlines.
20.2 Management control environment (Needs Improvement) *A process should be put in place to enable the FAC to exercise scrutiny over key judgements made by management in applying accounting policies and in making accounting estimates, prior to the Board being asked to approve the financial statements.*	As part of preparations for the end of FY2024 and annual audit, Health NZ will prepare a paper to the FAC. This paper will outline all the Annual Report balances where key judgements are made by management in applying accounting policies and in making accounting estimates. This includes the critical judgements in accounting policies and critical accounting estimates and assumptions disclosed in Note 1 to the financial statements. Health NZ will provide details of the approach we employ to establish reliable values for the key judgement areas, including details of any external expert resources engaged to assist. A paper on the key judgements made by management in applying accounting policies and in making accounting estimates was provided to the FAC on 8/3/24. Ongoing updates will be provided to the FAC as work occurs towards finalising results for FY2024.
20.3 Management control environment (Needs Improvement) *Health NZ has made a start on completing a fraud risk assessment but needs to complete a comprehensive assessment across the organisation and update this periodically. The fraud risk assessment should be shared with the FAC and the Board and used as an input into the annual Internal Audit Plan/Programme of Work.*	A comprehensive fraud risk assessment has been conducted across Health NZ. The draft report (including agreed-upon management actions) is in the final stages and is due to be presented to the FAC and Board in April 2024. The output of the assessment will feed into the organisational risk management processes, which will manage and update it on an ongoing basis. Details from the assessment will also (along with other sources of information) feed into the prioritisation of areas for assurance in the annual Internal Audit Plan/Programme of Work by June 2024.
20.4 Management control environment (Needs Improvement) *Health NZ has yet to introduce a system to enable positive assurance to be provided to senior management and the Board on the organisation's compliance with legislative obligations. Health NZ should put a system and procedures in place to monitor compliance with legislative requirements and provide assurance to senior management and the Board that legislative requirements are being complied with.*	Following the health sector reforms, legislative compliance has continued to be managed largely through new national policies or (in areas where national policies have not yet been established) existing local policies (i.e. district or shared services policies). Furthermore, there are compliance reporting systems via which staff may report legal risks, potential breaches, and clinical and health and safety risks. One example is the Health Integrity Line, which enables staff and others to anonymously report (either via phone or online) fraud, policy breaches or any other concerning matters relating to Health NZ.

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Item	Health NZ Response
	As policies are the primary mechanism for ensuring compliance, Health NZ started a Policy Harmonisation Programme (PHP) in December 2022. The PHP will assess which policy aspects are relevant for all staff, align policies with legislation and best practice, and create a repository of clear, up-to-date, accessible and approved policies for everyone. A legislative compliance policy is expected to be developed as part of the PHP. Once this policy is finalised and rolled-out, we will consider an appropriate compliance assessment framework.
20.5 Financial information systems and controls (Needs Improvement) *General information technology controls:* – *password settings should be consistently aligned to good practice;* – *ensure user access settings are regularly reviewed and current; and* – *reconsider business continuity and disaster recovery plans based on the opportunities from an integrated national organisation.*	Data and Digital are progressively working to strengthen Health NZ's security posture and the resilience of the ICT ecosystem. ▪ **Password settings.** Although many of our systems are compliant, not all are capable of meeting the New Zealand Information Security Management (NZISM) standard. These system constraints are being progressively addressed through upgrades and application modernisation, and managerial controls will be strengthened by the Identity and Access Management (IDAM) solution (see below). ▪ **System access.** Basic access provisioning controls are in place for individual applications. For example, while Health NZ is now a national entity, local policies and practices for removing access from systems (triggered by an exit notification) remain in place. Health NZ also has the 'macro level safeguard' of network access controls, which sits above individual application access. This means that people require access to the network, and being deactivated prevents a person accessing the vast majority of individual applications. The key improvement opportunity is to strengthen controls via the Active Directory. A national policy to deactivate the overall accounts after a defined period of inactivity will be rolled out across the country. This would mean that people lose access to the Health NZ network and therefore can no longer access the systems. Business Owners of the relevant applications will also conduct annual reviews around levels of access, based on information provided by Data and Digital. In addition, the use of generic accounts will be restricted to mitigate the associated risks. A programme of work is underway in the Identity and Access Management (IDAM) space to provide managers with direct control over access and privileges. The initial go-live, scheduled for Q1 of FY2025, will deliver base capability to core services. Over the next three years, functionality will be rolled out to legacy systems. In addition, overarching Data and Digital policies will be signed off by Q3 of FY2025. ▪ **Strengthening of disaster recovery.** A key distinction has been made between Disaster Recovery (DR) (restoring hardware, software and data) and Business Continuity Plans (BCPs) (the processes required to continue functioning without Data and Digital services). Data and Digital has the accountability for DR and individual business units have the accountability for BCPs. Artificial intelligence (AI) and machine learning powered software have been deployed to help us understand our application landscape and provide insight around our current infrastructure. This will assist in planning the approach to DR across the country and building on existing controls in place. In addition, targeted investments are planned to upgrade and remediate the most critical areas of technical debt. This is being prioritised nationally to ensure Health NZ allocates funds to the areas of greatest need. However, it should be noted that disaster recovery solutions are generally provisioned at the individual application level, so there are limited synergies from being a national entity. Disaster recovery capabilities will ultimately be improved for all applications as part of the Digital Modernisation investments (including migration to hybrid-multi cloud solutions in some cases). A list of priorities has been established in Q2 FY2024 as part of Budget 24. The timetable for resolution will be informed by the timeframe for Digital Modernisation investments, with further clarity expected as part of the upcoming budget preparations.
20.6 Financial information systems and controls (Needs Improvement)	There is currently an interim Sensitive Expenditure policy, which applies to staff employed in the National office. An organisation-wide policy will be created as part of the PHP (see

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Item	Health NZ Response
Policies, procedures, and practice in relation to sensitive expenditure are not in line with current good practice. We found instances where transactions did not comply with policy, they were not coded to the correct account, or they did not follow a 'one-up' approval principle: – *policies should be reviewed and updated to meet current good practice, and management and staff should be suitably trained on the policies and procedures and on exercising judgement as to what is reasonable expenditure;* – *Health NZ should ensure the 'one-up' approval principle is followed and appropriate evidence of the approval is retained; and* – *a monitoring and reporting regime should be implemented for sensitive expenditure incurred.*	above) and will ensure the recommendations raised in this report are addressed. The Sensitive Expenditure Policy has close links with a number of other policies, which will need to be reviewed at the same time to ensure completeness, consistency and conciseness. As national policies are developed, Health NZ will ensure people are suitably trained and supported to understand them. Health NZ's Internal Audit team are carrying out an audit of sensitive expenditure nationwide (covering 29 entities) and applying the AOG Guidelines on sensitive expenditure (i.e. not relying solely on the districts' policies). The internal audit coverage is the entirety of FY2023.
20.7 Financial information systems and controls (Needs Improvement) *Systems and processes need to be put in place to identify the related party transactions that are required to be disclosed in the notes to the financial statements.*	At the end of FY2024, all identified related party entities will be reviewed in Health NZ ledgers to identify any non-arms-length transactions. Internal Audit RPA tools are currently running over the Companies Office data looking for related parties. These will be updated to include Board and ELT members.
20.8 Performance information and associated systems and controls (Needs Improvement) *Two former districts were unable to provide supporting records for the information on cardiac surgery they submitted during the 2022/23 period. We were therefore unable to verify results to underlying data/records. Point in time information and supporting records should be retained by all areas that carry out cardiac surgery.*	Historically, the Ministry of Health did not maintain a centralised database on whether cardiac surgery patients had received treatment within their recommended timeframe. Data was collated from systems (e.g. the patient management system, theatre lists, individual cardiac reports) and reported by individual district health boards for internal use. Further complicating the ability to verify data, each district had different methods of recording their respective waiting list data. Two districts advised that certain aspects of collating cardiac data were not within a database that can be recalled, as the source where data is held is refreshed on a regular basis, removing previous information used to provide earlier data. Data may have been able to be verified by accessing individual patient records. However, this was not considered to be reasonably practicable within audit timeframes. Although Health NZ initially inherited the decentralised approach, we have now established the National Cardiac Network. The work plan for this Network includes collecting for cardiac surgery and cardiology and ascertaining the appropriate method of collating meaningful KPIs electronically. For FY2024, Health NZ is proposing a change to the metric (via the Supplementary Estimates process) to 'The percentage of patients (both acute and elective) who are waiting for treatment beyond 120 days'. This measure can be verified by data extracted from the National Minimum Dataset in National Collections, which records when a patient is waitlisted and discharged.
20.9 Performance information and associated systems and controls (Needs Improvement) *It is important for Health NZ to be able to tell its performance story well. The annual report would benefit from a clear performance framework and an overall summary of where the system is performing well and where it is not across output classes. Having a consistent structure for presenting performance information for each output class would help the reader to understand the performance information.*	Health NZ is currently developing an entity-wide performance framework. This will be implemented from July 2024. The *Health New Zealand | Te Whatu Ora 2023/24 Annual Report* (which will be published in November 2024) will include, where possible, an overall summary of where the organisation is or is not performing well. This will enable readers of the report to easily understand overall performance.
20.10 Performance information and associated systems and controls (Needs Improvement) *There was limited reporting of sub-national performance information in the annual report. Health NZ should continue to expand the number of measures where performance is reported on a sub-national basis to better enable readers to understand the variability that exists, the action(s) Health NZ is undertaking to address any variability and whether progress is being made to reduce this.*	The *Health New Zealand | Te Whatu Ora 2023/24 Annual Report* will, where possible, include more granular geographic and ethnicity data and narrative. This will reflect any unwarranted variability in performance and highlight the actions taken to address this. Discussions have already begun to ensure Health NZ has the resources to include full-year performance, particularly, where possible, data reflecting sub-national performance.

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Item	Health NZ Response
20.11 Performance information and associated systems and controls (Needs Improvement) *The coverage and depth of the descriptions and explanations of performance, particularly when targets are not met, should be enhanced.* *For a number of measures, only quarter four results were reported. For some other measures, results were only available up to 31 March 2023. Service performance information should be presented for the full year.*	Health NZ is working towards ensuring a better performance story is told across all reporting. The Audit New Zealand recommendations will be applied to the commissioning and refinement of the *Health New Zealand | Te Whatu Ora 2023/24 Annual Report*.
20.12 Performance information and associated systems and controls (Needs Improvement) *National data sets used for reporting service performance information should be reconciled with data sets held in individual patient management systems (at local level) on a regular basis and differences identified and resolved prior to year-end. Health NZ should ensure that listings are comparable across the country.*	Health NZ has already implemented the following changes to improve data integrity: ▪ Processes are in place for districts to monitor their ED data in the National Collection (NNPAC) and amend records if necessary. ▪ Qlik apps are available to district staff to enable visibility of their data in National Collections for easy comparison back to their local reports. ▪ A quality assurance process has been introduced which requires sign-off of data validity by Chief Medical Officers and Health Analytics Managers. ▪ Sign-off by the Group Directors of Operations in each district is required for each quarter starting Q2 FY2024. Additional measures planned are: ▪ Communication with district staff will be managed differently for the next audit to ensure they are aware of scope, including end-to-end auditing of their data. This will commence in April 2024. ▪ A Measures Library will be established to make data definitions easily accessible to district staff. The first version will be published by 30/6/24. ▪ Permissions to access identifiable health data for the Audit NZ team will be facilitated early in the cycle to enable timely access to randomly selected records. A privacy impact assessment (PIA) has already been documented and will be shared with districts prior to the audit.

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Event Briefing

Connect 24

To:	Hon Dr Shane Reti, Minister of Health	Reference:	HNZ00041107
From:	Aroha Haggie, Event Project Lead	Due Date:	27 March 2024
Copy to:	n/a	Security level:	In Confidence

Contact for telephone discussion (if required)			
Name	**Position**	**Telephone**	**1st contact**
Aroha Haggie	Event Project Lead	S 9(2)(a)	x
Margie Apa	Event Project Sponsor		

The following departments/agencies have been consulted
n/a

Attachments
Appendix 1: Programme **Appendix 2:** Speech notes sent separately

Connect 24

Meeting Visit details

Date: Wednesday 27 March 2024

Venue: Sky Stadium, Wellington

Time: 9am to 10:15am

Purpose of meeting/visit/event

Delivering a keynote speech at Connect 24; a session for the top 300 leaders at Health New Zealand | Te Whatu Ora.

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Expected Attendees	Dame Karen Poutasi, Board Chair Margie Apa, Chief Executive, Riana Manuel, Chief Executive, Te Aka Whai Ora Tana Umaga, Rugby and leadership coach 300 leaders from Health New Zealand
Media	No media expected

Background

Connect24 brings the top 300 Leaders across Health New Zealand together for the first time.

The purpose of Connect24 is to connect to Health NZ strategic context, connect as a team of teams and connect with each other as people leaders.

It is the first time a meeting like this has taken place since Health New Zealand was established.

Connecting with our strategic context means understanding the pr orities from our authorising environment. This includes Minister of Hea th, Dr Shane Reti and our Board Chair, Dame Karen Poutasi, speaking to the expectations of us as a system.

Connecting with our team of teams means hearing about work that is being undertaken across the organisation and providing leaders with the opportunity to provide their national, regional and local knowledge for how we shape and implement those initiatives going forward.

It's an opportunity for leaders to connect with each other as people leaders. Also to take messages and information and sha ed learning back to their teams.

Run sheet

Your key contacts for the day will be:

- Margie Ap   Chief Executive
- Mahaki Albert, Chief of Tikanga
- Dinah Nichols, EA to Margie Apa (021 682 923)
- Maxine Stead, GM Internal Communications (021 477 796)

Time	What	Who
9.00 am	Minister arrives at level 1 Foyer, Sky Stadium	Met by Mahaki Albert
	Escorted to level 4	Mahaki Albert

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9:15am	Introduced to audience	Margie Apa
9.16am	Minister presents	
	Optional Q & A – Minister to confirm	
10:10am	Minister thanked for speaking	Andrew Slater
10:15 am	Minister leaves	

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CONNECT 24

Thank you for making the time to attend the Connect 24 Leaders' hui.

Date, time and venue

Tuesday 26 March 2024

8:00am – 9:00am Breakfast

9:15am – 5:45pm Main session

Wednesday 27 March 2024

8:00am – 8:45am Breakfast

9:15am – 5:00pm Main session

Venue: Sky Stadium, 105 Waterloo Quay, Pipitea, Wellington 6140

Purpose

- Connect with strategic context.
- Connect with future directions.
- Connect with enablers of care.
- Connect with outcomes and innovation.
- Connect as leaders.

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Programme				
Day 1: Tuesday 26 March 2024				
Time	**Session**	**Presenters**	**Room**	**Level**
8:00am	Registration Breakfast		Level 1 Foyer Level 4 Members Gallery East	1 4
9:15am	Open with Karakia	**Mahaki Albert** **Kingi Kiriona**	Level 4 Members Gallery	4
	Housekeeping and welcome	**Facilitators**		
	Opening address and introductions	**Fepulea'I Margie Apa** Chief Executive **Riana Manuel** Chief Executive Te Aka Whai Ora		
	Ice breaker	**Joanie Sims** **Maria Lafaele**		
10:30am	Morning tea- opportunity to view exhibitions			
11:15am	**Workshop 1 – Connect with strategic context**			
	Iwi Māori Partnership Boards	**Teei Kaiaruna General** Manager Iwi Māori Relationships	Level 2 Aotea & Pipitea	2
	Health Status Report	**Dr Gary Jackson** Director Population Health Gain	Level 2 East	2
	Horizon scanning	**Dr Robyn Whittaker**	Level 2 West	2

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		Director Evidence and Research and Clinical Trials		
	Infrastructure Investment Plan	**Aaron Matthews** Head of infrastructure, Planning and Investment	Level 3 East	3
	Workforce Plan 2024/2025	People & Culture	Level 4 Members Gallery	4
	NZ Health Plan	Office of CE	Level 4 Members Lounge	4
12:15pm	**Workshop 2 – Connect with future direction**			
	Pacific Health Strategy An overview of Pacific health commissioning strategies and models of care.	**Epenesa Olo-Whaanga** Head of Commissioning, Pacific Health	Level 2 Aotea & Pipitea	2
	Re-imagining primary care	**Martin Hefford** Director Living Well	Level 2 East	2
	Improving access to planned care Achieving outcomes and performance by partnering with HSS regional teams.	**Duncan Bliss** Group Manager Planning	Level 2 West	2
	Health behaviour change Addressing modifiable behaviours to reduce the risk of non-communicable diseases	**Dr Hayden McRobbie** Regional Director (Northern) NPHS	Level 3 East	3
	What is transformation?	Transformation	Level 4 Members Gallery	4
	Maximising value and improving productivity *(originally called Budget setting and delegations)*	**Rosalie Percival** Chief Financial Officer	Level 4 Members Lounge	4
1:00pm	Lunch - ELT Clinics and opportunity to view exhibitions		Level 4 Members Club Room	4

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2:00pm	This isn't tiddlywinks - Leaders as Coaches'	**Tana Umaga** Super Rugby Coach	Level 4 Members Gallery	4
3:00pm	Our health system	**Dame Karen Poutasi** Board Chair		
3:45pm	**Workshop 3 – Connect with enablers of teams**			
	Facility design and standardisation Standardising design guidance and processes.	**Stacey Marsh** Head of Asset Management	Level 2 Aotea & Pipitea	2
	Campus and service planning	**Rachel Haggerty** Director, Service Strategy **Lisa Smith** Acting General Manager Commissioning (HSS)	Level 2 East	2
	National Data Platform The three horizons of investment and 12 flagship initiatives. *(originally called digital modernisation)*	**Leigh Donoghue** Chief of Data and Digital	Level 2 West	2
	Clinically focused health analytics *(originally called Clinical quality and safety measures)*	**Delwyn Armstrong** Director Health Analytics **Dr Andrew Salmon** Nephrologist, Waitematā **Derek Sherwood** Ophthalmologist,Planned Care National Clinical Lead	Level 3 East	3
	How do we make Health NZ more transparent for our staff and the public?	Office of the Chief Executive	Level 4 Members Gallery	4
	It Takes a Village. How NPHS has brought their operating model to life *(originally called leading through change kawanga whare)*	**Dr Maria Poynter** Director, Transformation **Rachel Prebble** Organisation Development Lead	Level 4 Members Lounge	4

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		Graham Cameron Director, Māori Public Health **Api Poutasi** Director, Pacific Public Health		
4:45pm	**Workshop 4 – Connect with enablers of care**			
	Enterprise Portfolio Office	Transformation	Level 2 Aotea and Pipitea	2
	AI Horizon scans	**Dr Robyn Whittaker** Director Evidence, Research and Clinical Trials	Level 2 East	2
	Clinical Networks	**Mary Cleary-Lyons** Director, National Clinical Networks **Rawiri Jansen** Chief Medical Officer **Richard Sullivan** Chief Clinical Officer	Level 2 West	2
	Whānau voice	Te Aka Whai Ora	Level 3 East	3
	Commissioning for outcomes *(originally called maximising value and improving productivity – moved to the morning session)*	Te Aka Whai Ora	Level 4 Members Gallery	4
	Digital workspace	**Leigh Donoghue** Chief of Data and Digital	Level 4 Members Lounge	4
5:30pm	Photo shoot - All leaders			
5:45pm	Conversations, nibbles and cash bar		Level 3 Members Club Room	3

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Programme				
Day 2: Wednesday 27 March 2024				
Time	**Session**	**Presenters**	**Room**	**Level**
8:00am	Registration Breakfast		Level 1 Foyer Level 4 Members Gallery East	1 4
9:00am	Open with Karakia	**Mahaki Albert** **Kingi Kiriona**	Level 4 Members Gallery	4
	Housekeeping and welcome	**Facilitators**		
	Reflections on Day one	**Fepulea'I Margie Apa** Chief Executive		
	Setting a vision	Health Minister, **Hon Dr Shane Reti**		
10:40am	Morning tea- opportunity to view exhibitions			
11:25am	**Workshop 1 - Connect with enablers of outcomes and innovation 1**			
	Disability capability maturity matrix A self-assessment tool for capability and approach to disability equity.	**Rachel Noble** Head of Disability	Level 2 Aotea and Pipitea	2
	Acute flow How do we support alternative choices for patients and prevent the need to attend hospital?	**Rachel Haggerty** Director, Service Strategy **Duncan Bliss** Group Manager Planning	Level 2 East	2

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	Kia kaua au nga kino e puta mai ki te tangata Maori Practical tools in public health to give effect to Te Tiriti o Waitangi. *(Replaces Indigenous models – Te Tiriti implementation tool)*	**Graham Cameron** Director of Māori Public Health, NPHS	Level 2 West	2
	Slowing the progression of diabetes National Diabetes Action Plan, focussing on prevention, early detection and effective management.	**Markerita Poutasi** National Director Pacific Health	Level 3 East	3
	Social investment	Commissioning	Level 4 Members Gallery	4
	Health targets	Office of the Chief Executive	Level 3 West Lunch Room	3
	Innovation Funnel	**Dr Penny Andrew** Director Te Whatu Ora Improve	Level 4 Members Lounge	4
12:25pm	**Workshop Session 2 - Connect with enablers of outcomes and innovation 2**			
	Māori Health pipeline	**Dr Karen Bartholomew** Director Health Equity	Level 2 East	2
	Social Marketing to support engagement with whānau and communities Part of a comprehensive approach to health promotion.	**Kathrine Clarke** Director, Promotion, NPHS	Level 2 West	2
	We build this system on rock and roll. From pandemic and emergency to a sustainable public health system. *(Originally called Pandemic preparedness)*	**Becky Jenkins** Director Protection, NPHS	Level 3 East	3

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	Community Engagement and Whānau voice	**Hector Matthews** Director Consumer Engagement and Whānau Voice	Level 4 Members Gallery	4
	Digital modernisation Digital initiatives to support community, whānau and Equity initiatives.	**Michael Dryer** Director Digital channels, Data and Digital	Level 4 Members Lounge	4
	FASD – there is a prevention way out *(originally called Te Aka Whai Ora)*	Te Aka Whai Ora	Level 2 Aotea and Pipitea	2
1:10pm	Lunch - ELT Clinics and opportunity to view exhibitions		Level 4 Members Club Room	4
2:25pm	Panel discussion - connecting with regions	Regional Integration Teams	Level 4 Members Gallery	4
3:25pm	**Workshop 3 – Connect with regions**			
	Te Manawa Taki	**Nicola Ehau**	Level 2 East	2
	Te Waipounamu	**Mata Cherrington**	Level 2 West	2
	Central region	**Tricia Keelan/ Patrick Le Geyt**	Level 4 Members Gallery	4
	Northern region	**Tracee Te Huia**	Level 4 Members Lounge	4
4:30pm	Closing remarks	**Fepulea'I Margie Apa** Chief Executive	Level 4 Members Gallery	4
4:45pm	Karakia and close	**Mahaki Albert** **Kingi Kiriona**		

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Aide Memoire

Hospital and Specialist Services- Hotspots

To:	**Hon Dr Shane Reti, Minister of Health**	Reference:	**HNZ00041204**
From:	Fionnagh Dougan, National Director, Hospital & Specialist Services	Due Date:	22 March 2024
Copy to:		Security level:	In Confidence

Contact for telephone discussion (if required)			
Name	**Position**	**Telephone**	**1st contact**
Fionnagh Dougan	National Director, Hospital & Specialist Services	S 9(2)(a)	
Sally Dossor	Head of Office and Business Support, Hospital & Specialist Services		x

The following departments/agencies have been consulted
If required – *note this section refers to external departments/agencies, not internal directorates or regions.*

Attachments
Appendix 1: **Appendix 2:** **Appendix 3:**

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Purpose

You requested a summary update that provides the context, actions, risks and opportunities of three identified 'hotspots':

1. Canterbury / Waitaha,
2. Palmerston North, and
3. Hawkes Bay.

Te Kāwanatanga o Aotearoa
New Zealand Government

Health New Zealand
Te Whatu Ora

Key Summary

The Hospital and Specialist Services (H&SS) Senior Leadership team have identified three hospital sites/districts requiring rapid assessment and action (referred to as 'hotspots').

Across the three hotspots, there is a diverse range of geography, population need and infrastructure variation which means they each have different challenges and paths to resolution. In addition, 2 of the organisations (Waitaha and Mid Central) have Ope ational Performance and Productivity challenges relating to Planned Care and Urgent Care Flow.

While the scale and intensity of issue across the three cannot be directly compared, there are key issues, common to all:

- Specialist Workforce and Capacity Issues,
- Digital Infrastructure and Service Delivery Models,
- Data Quality, Performance Management and Management Information,
- Leadership and Governance, and
- Patient Care and Quality of Services.

Action plans are progressing for each hotspot, led by the district teams, and supported by relevant expertise.

Intensive Support teams (IST)

The H&SS Senior Leadership Team has worked together with the H&SS Delivery Unit to develop an intervention methodology and playbook – through Intensive Support Teams. These teams are stood up for hotspot areas, based on consistent thresholds and triggers. These teams:

- Rapid, time-limited intervention,
- Activated by H&SS Delivery Unit with the support of RD and GDO,
- Objective assessment of local performance challenges,
- Interactive development of action plan with, and to be owned by, District teams,
- Prov de or facilitate deployment of targeted support for Districts' implementation of action plan,
- National and regional visibility of performance challenges and solutions,
- Consistent approach to performance improvement, and
- Opportuni y fo standardisation across H&SS.

Discussion

Canterbury - Waitaha

From March 2023, monthly regional performance reviews have been conducted by the H&SS national team that have systematically identified issues in the district. In August 2023, the District was placed into high intensity support on Planned Care. In October 2023, we placed an Improvement Director into Waitaha (Jo Gibbs) to provide pace and focus on key operational constraints and performance challenges.

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This district currently has an acting Regional Director and an acting Group Director of Operations (GDO).

Summary of risks and issues

- Planned care delivery in Canterbury will be challenging to deliver to the target because of large waiting lists in some specialties, longer waiting times for treatment, higher access thresholds and the capability of managers in dealing with the recovery programme.
- Leadership, culture and staff trust in Canterbury continue to be risks across senior clinical and operational roles.
- There is an overcrowded emergency department, and a strategy to resolve this is currently in progress. High occupancy in ED means that achieving planned care targets is constrained.
- There are unrealised opportunities with the use of the Burwood Campus.
- Waiting times for Mental Health & Addiction services con inue to grow across the district driven by high demand coupled with capacity and workforce constraints

Next steps and actions

- Strengthening hospital leadership – clinical and operational:
  - This includes reviews of the structural models and future options and introducing new models with external providers and partners.
  - Leveraging the H&SS Intensi e Support Team (IST) process to establish strong and credible lea ership and deliver a clear strategy to meet targets.
- Uplift decision making and operating model practices
  - This includes driving consistent cadence and operational management meetings across Canterbury.
  - This includes delivering a campus strategy that will better utilise the Burwood Campus to improve service and care delivery.
  - Specif c programmes around improving target delivery for specialist mental health services, planned care acute care and cancer.
- Embed s ronger Clinical governance practices and processes.
- Improving the use, quality, and availability of management information across all levels of Clinical and operational leadership.
- Establishing a financial sustainability and productivity improvement programme to improve key drivers such as theatre utilisation, outpatient scheduling, production planning and driving savings initiatives through productivity uplifts.

Palmerston North (MidCentral)

Past reviews of Palmerston North have identified issues with performance, culture and clinical quality and safety. The current focus and action plan led by an Improvement Director (Kevin Snee) is incorporating the outstanding actions from former reviews and identifying a comprehensive action plan for this site with objectives that are SMART.

Summary of risks and issues

- MidCentral continues to be a low performer on acute care performance across Short Stay ED (SSED) and in ED and hospital occupancy.

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- Urgent care performance is at a critical performance level and there is further analysis being undertaken relating to performance and clinical quality.
- Senior clinical leadership recognise that models of care are insufficient, and a cultural shift is required, including new leadership for nursing and other professional areas.
- Standards of care, leadership, culture and staff trust in MidCentral remain a risk across senior clinical and operational roles.
- The issues being experienced in MidCentral will not be a short-term fix and will take considerable time to drive and realise the required change.

Next steps and actions

- The H&SS national team will continue to work with an Improvement Director to embed the required actions locally to drive and manage the turnaround efforts.
- This Executive leader will provide support for a 12-month te m to deliver the cu tura improvements.
    - This is essential to establish and strengthen the enduring leadership team.
- A further review of the critical care model will be conducted.
    - An expert will be commissioned to work rapidly with leadership a rev ew of the model of care for critical care-incorporating Emergency medicine and Intensive and High Dependency care.
- The actions are focused on moving Palmerston North (MidCentral) to work regionally around service sustainability and resilience

Hawkes Bay

Summary of the risks and issues

- Hawkes Bay Hospital is experiencing challenges in:
    - acute patient flow, as evidenced by access block,
    - high bed occupancy levels
    - patients being cared for in departments not designed for inpatient care d livery due to a current and forecasted deficit in the number of points of care that has been well evidenced in the Clinical Services Plan, and
    - facilities that are aged and, in some areas, no longer fit for purpose.
- This is having an impact on clinician wellbeing and engagement, consumer and whānau experience and quality of care and safety.
- Recruitment to the Group Director of Operations (GDO) position has been challenging

Next steps and actions

- Support the Acting GDO to create a tangible and focused improvement and development plan for the senior leadership team that will address patient flow.
- Enhance and improve communication and engagement activities across the organisation.
    - This is to improve and drive staff engagement to create a safer and more effective workplace for clinicians.
- Implementing a quality improvement plan to rectify current issues and future quality risks.

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- Continue to progress, at pace, approval of the tactical project business cases that will address current deficits in the number of points of care, which includes as a priority the Temporary Inpatient Unit and Radiology.
- Continue to progress the Hospital Redevelopment Programme and additional tactical projects that will address forecasted deficits in the number of points of care and provide appropriate services to the Hawke's Bay community.

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Aide-Mémoire

2023 System Pressures (Winter) Plan Review

To:	Hon Dr Shane Reti, Minister of Health	Reference:	HNZ00039244
From:	Abbe Anderson, National Director, Commissioning	Due Date:	27 March 2024
Copy to:		Security level:	Unclassified

Contact for telephone discussion (if required)			
Name	Position	Telephone	1st contact
Danny Wu	Regional Wayfinder Northern	S 9(2)(a)	x
Abbe Anderson	National Director Commissioning		

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Purpose

1. This paper responds to your request for information on the evaluation of the 2023 System Pressures Preparedness Plan (the Winter Plan), including information about what the initiatives cost and how much of that spend is forecast for the 2023/24 financial year.

2. Note, a paper on system pressures for 2024/25 is currently being developed and we will provide you with further advice on these initiatives by the end of April.

Background

3. To respond to the normal seasonal increase in pressure across the health system as a result of winter ailments, in early 2023 Health New Zealand | Te Whatu Ora (Health NZ) introduced a nationally consistent system pressures operating model to prepare for the upcoming winter period. This included a focus on meeting obligations under Te Tiriti o Waitangi, improving access to quality, timely, and culturally-safe health care, and ensuring partnership with providers and communities, with a focus on reducing the burden on hospital services, in particular, Emergency Departments.

4. From this, Health NZ developed a national plan (the Plan) to address some of the key pressures that the acute care system faces in the winter months.

5. A package of 24 initiatives was planned for implementation across Health NZ, with the focus on what was actionable for winter 2023. Many of the initiatives were part of longer-term actions to address pressures across the system, and the package included a strong emphasis on primary and community care. The key goals of the Plan were to:

- Reduce, or slow growth of, acute demand through prevention, early intervention and timely delivery of care in the community;
- Provide timely access to acute care across the whole system that is efficient, safely resourced, and improves staff experience;
- Enable people to return home to their communities in a safe and timely way, with the support they need to keep them well at home.

6. The 24 initiatives fell into eight areas outlined below. While many of the initiatives were national, others were targeted in eight regions with consistent hospital flow challenges and wider system pressures (Whangarei, Middlemore, Auckland, Tau anga, Palmerston North, Wellington, Christchurch and Invercargill). The eight areas were:
    - Increasing immunisation to protect from severe illness and hospitalisation;
    - Reducing and mitigating system pressures in primary and community settings;
    - Preventing hospital admission and ensuring timely hospi al discharge;
    - Reducing system pressures by improving acute flow;
    - Maintaining planned care delivery under system pressure;
    - Addressing workforce pressures and supporting staff;
    - Reducing system pressures through communications and behaviour change;
    - Reducing the impact of COVID-19 on system pressures
7. An evaluation of the Plan was undertaken at the end of winter. The full evaluation can be provided if requested.

Discussion

A key finding was that few conclusions could be drawn

8. Overall, the evaluation was unable to provide conclusive evidence that the Plan had a direct impact on system pressures, nor was it able to say that the Plan had no impact. Little was able to be drawn about the cost-effectiveness of the initiatives in the Plan. This is due to range of contributing factors, including:
    - The evaluation was not designed at the start with clear lines from initiatives to outcomes measures and with adequate baseline measurement, in part due to the complex interplay between initiatives, business as usual and timelines;
    - Limitations in the outcomes measured and the aggregation of these to a national level, and in data quality (completeness and consistency);
    - The inclusion of a large number of initiatives meant determining any change due to the Plan is difficult.
9. The evaluation does show that it appears more care was delivered in the community for prevention and early intervention, such as clinical telehealth for ambulance services,

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pharmacy prescribed medications and minor ailments consultations, community radiology referrals, vaccinations and a communications campaign.

10. The evaluation also showed that while some stakeholders1 were uncertain that there had been an impact on acute demand, they were supportive of several of the initiatives, including primary options for acute care (POAC), pharmacy minor ailments and community radiology.

The equity intention was present in the Plan, but not always in the implementation

11. In terms of equity, the evaluation noted there was clear intent to specifically improve outcomes for Māori and there was evidence of resource targeting, inc uding within the pharmacy minor ailments and Primary Options in Acute Care (POAC) nitiatives, prioritised contracting with Māori and Pacifica providers, funding for manaaki support of people in the community, ring-fenced funding for Very Low-Cost Access (VLCA) practices and rural telehealth.

12. However, it was noted that time constraints reduced the ability to co-design init atives with Māori and Māori providers, while also creating a situation where implementation may not have been consistent on the ground. Many of the utilisation/access measures for individual initiatives showed Māori remained under-represented in terms of access, even where there may have been spec fically targeted actions. In system level measures, many were not able to be examined by ethnicity, and where they were there was no evidence of a greater impact of the Plan for Māori

Multiple contextual factors impacted the Plan

13. The evaluation noted that systemic changes in the health sector over the period of the Plan appear to have impacted many aspects of the work, including planning, timelines, leadership, engagement, relationships and communications. Taken together, these are crucial aspects in the implementation of any programme of work, and when put alongside the impacts from the ongoing recovery from COVID-19, workforce issues, and the landscape of consistent respiratory illnesses, it would be difficult for any large-scale programme of work to be immediately and obviously successful.

Recommendations from the Evaluation

14. The evaluation provides recommendations that future national planning for system pressures be continuous, focused on specific areas, and include co-design with key stakeholders across sectors. Specific areas of focus could be:

    - A small number of community-based initiatives (eg, telehealth) that involve whole of sector engagement and support at the district (or appropriate) level. These will require co-design and targeting of appropriate activities with Māori providers and communities, as well as Pacific and others.

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[1] Stakeholders included representatives from the sector, including: Government, Primary Health Organisations (PHOs), Pharmacy, Hospital, Ambulance services and other organisations, with roles ranging from clinical leads and management positions to frontline healthcare.

- Separate hospital flow-based activities should be undertaken that are comprehensive and involve all necessary parts of the sector (including those involved in entry and exit pathways). It might be useful to focus on particular subgroups, such as the elderly, but to focus on the clear pressure points/blockages along the patient journey.

Cost Implications

15. Some funding was made available from baseline to support the initiatives in the 2023/24 financial year. Because not all 24 initiatives required funding from the winter pressures pool, the list below details those with winter pressures funding attached. This spend continues to be monitored, as further costs will be incurred out of this targeted funding over April to June 2024.

16. The $42 million funding has been allocated across the measures as below:

Initiative	Budget 2023/24	Forecast Spend	Comment
Remote patient monitoring	$1.183m	$1.183m	
Minor ailments	$6.372m	$5.500m	
Community radiology	$3.120m	$1.600m	
POAC	$22.755m	$20.331m	
More accessible Urgent care	$0.850m	$8.000m	(initial stabilisation funding for targeted urgent care)
Vaccination home support workforce	$1.421m	$0.026m	Low uptake/claiming by the sector
Telehealth for ARC	$0.454m	$0m	Did not progress
Complex discharge	$6.000m	$6.000m	
TOTAL	$42.155m	$42.640m	

17. We expect the full $42 million put aside for winter pressures will be spent by end of June 2024, noting that some of this funding has been targeted at the upcoming winter period (April to June 2024).

Next steps

18. The 2024 System Pressures Plan is under development, taking account of the evaluation findings and learnings. This plan is currently being finalised and a further paper will be provided to your office summarising it by the end of April.

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Event Briefing

Flu Immunisation Launch Event

To:	Hon Dr Shane Reti, Minister of Health	Reference:	HNZ00041914
From:	Dr Nick Chamberlain, National Director, National Public Health Service	Due Date:	27 April 2024
Copy to:		Security level:	Unclassified

Contact for telephone discussion (if required)			
Name	**Position**	**Telephone**	**1st contact**
Alana Ewe-Snow	Director, Prevention, National Public Health Service	S 9(2)(a)	x

The following departments/agencies have been consulted
N/A

Attachments
Appendix 1: Runsheet **Appendix 2: Media release** **Appendix 3: Q&As**

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Flu Immunisation Launch Event

Visit details	**Date** 2 April 2024 **Time** 3pm **Venue address** The Fono, 33 Wyndham Street, Auckland CBD, Auckland 1010
Purpose of event	To launch the winter flu vaccination campaign.
Expected Attendees from the Fono	Fiugalu Tevita Funaki MNZM - CEO of The Fono Sally Dalhousie - COO Dr Malia Funaki - Clinical Director Jennifer Tupou - CFO
Te Whatu Ora representatives	Markerita Poutasi, National Director, Pacific Health Dr Richard Sullivan, Interim Chief Clinical Officer Alana Ewe-Snow, Direc or Prevention, NPHS Harriet Pauga, Pacific Regional Director, Northern Maria Lafaele Head of Office of the National Director, Pacific
Media	Media stand up to take place at the start of the visit. A media advisory will be issued the day prior. Te Whatu Ora media contact: Tracie Simpson, S 9(2)(a)

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Talking points

Today we are launching the 2024 winter flu immunisation campaign, which is an important part of getting our communities ready for winter.

Every winter, we see an increase in hospital admissions for respiratory infections and other illnesses associated with the 'flu season.'

Vaccinations are a first line of defence against severe winter illnesses. Getting the vaccine helps protect you against catching the flu in the first instance and helps reduce the ikelihood of severe illness if you do get infected.

It also helps to stop the spread of flu around your community, and helps protect those more likely to experien e severe illness from the flu, like older family members.

The flu can be much worse than a common cold and although having the vaccination doesn't guarantee you won't catch the flu, it will give you more protection if you do catch it

From today, the flu vaccine is free for people at higher risk of getting very sick from the flu including:

- People aged 65 years and over
- People who have a long term medical condition like diabetes asthma, or a hear ondition (ages 6 months+)
- Pregnant people
- Children aged 4 years and under who have been hospitalised for respiratory illness or have a history of significant respiratory illness
- People with men al health conditions, including schizophrenia major depressive disorder, bipolar disorder or schizoaffective disorder
- Peop e who are currently accessing secondary or tertiary mental health and addiction services.

People who are eligible can get a free vaccination through your local pharmacy, doctor, nurse or healthcare provider.

You can book your vaccination – either for yourself, another family member, or a group booking – through your healthcare provider or online at bookmyvaccine.health.nz or by calling 0800 28 29 26.

This is also a good time for families to be checking if their children's immunisations are up to date, particularly MMR. We know the harm measles has on communities but it's a disease that can be prevented with immunisation.

There are many other ways communities can prepare for winter to ensure they stay well over that period.

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Preparing our homes to protect from cold and damp conditions is good to do now whilst it's still a bit warmer.

It's also helpful to ensure we have care plans for any vulnerable family members, and remember to stay home if you are unwell to avoid spreading illnesses."

People who are eligible can also get support from the Healthy Homes initiative, which provides free support for eligible groups to make their homes warm, dry and healthy. This includes help with curtains, beds and bedding, accessing insulation minor repairs, ventilation, heating sources and a range of other support.

Those who are eligible include pregnant people, low-income families with children aged between 0 and 5 who have been hospitalised with a specified housing related condition, and families with children between 0 and 5 who have at least two of the social investment risk factors

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Background

1. This event briefing provides you with information to support your attendance at the launch of the winter flu vaccination campaign at the Fono in Auckland.

2. The Fono provides affordable services including medical, dental, social, pharmacy, health promotion, education and Whānau Ora spread across six locations in Auckland and Northland. Their services operate within an integrated mode of care. Delivering holistic and integrated care is core to their service delivery and has been for many years. They currently employ 206 people, the largest Pacific provider of integrated health services in Aotearoa.

Flu immunisation delivery

3. From 2 April, eligible people can get their free flu vaccinations from GPs pharmacies and other health providers.

4. The flu vaccine is free for people at higher risk of getting very sick from the flu including:

   - people aged 65 years and over
   - people who have a long-term medica condition like diabe es, asthma, or a heart condition (ages 6 months+)
   - pregnant people
   - children aged 4 years and under who have been hospitalised for respiratory illness or have a history of significant respiratory illness
   - people with mental health conditions, including schizophrenia, major depressive disorder bipolar disorder, or schizoaffective disorder
   - peopl who are currently accessing secondary or tertiary mental health and addiction services.

5. A range of outreach services providers will help to deliver flu immunisations in local communities. This includes hauora Māori and Pacific providers, as well as outreach services for Aged Residential Care.

6. For those who are not eligible for the free vaccinations, the flu vaccination is available at a small cost. Many workplaces also provide free vaccination programmes.

Flu immunisation promotion

7. Health NZ started its winter flu immunisation promotional activity on 18 March with direct communications (email, text). National advertising activity including TV, radio, digital, outdoor and press advertising will begin from 2 April. This first phase aims to reach the key audiences who are eligible for the free vaccination and encourage them to book an appointment.

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8. From 14 May, Health NZ will also be conducting flu advertising activity aimed at reaching all New Zealanders. This will encourage people to take up workplace vaccinations and paid vaccinations through GPs and pharmacies. This has been planned to reach 95% of the population aged 18+.
9. The campaign activity will cover a range of channels include TV advertising, radio, community press advertising, outdoor media, digital media, social media and online video.
10. Health NZ is also delivering a 'Shoo the Flu' campaign for Pacific peoples. This will launch from 11 April.

Author: Alexis Starkey, Interim Northern Region Communica ons Lead, Strategic Communications Lead, National Public Health Service Health NZ | Te Whatu Ora

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Appendix 1 – Runsheet

Time	Details	Minister's office notes
2.45pm	Media arrive to set up for the stand up. Address: The Fono, 33 Wyndham Street, Auckland CBD Contact: Tracie Simpson, Media Lead, Health NZ – S 9(2)(a)	[Leave this column blank – for Minister's office use only]
3.00pm	The Prime Minister and Minister Reti arrive at the front entrance to the Fono at 33 Wyndham Street. They are met by Markerita Poutasi and representatives from The Fono. (Park in the coned-off space within the drop-off area outside.)	
3.02pm	Lotu (prayer) by Moana Manukia (approx 5 mins. Led by a representative from the Fono.	
3.07pm	Media stand up to take place with the Prime Minister and Minister Reti. Dr Richard Sullivan will also be available to answer questions on the flu vaccination and winter preparedness.	
3.20pm	The Prime Minister and Minister Reti receive their flu vaccinations from staff at the Fono. TBC: Media will have an opportunity to film the vaccinations.	
3.25pm	Photo opportunity with the Prime Minister and Minister Reti, and staff from the Fono.	
3.30pm	Media stand up concludes. The Prime Minister and Minister Reti are taken to the upper level to meet with staff from the Fono. Vaccination staff will monitor the Prime Minister and Minister Reti for any side effects. Communications team members escort media to the exit.	
3.40pm	Markerita Poutasi and representatives of the Fono will take the Prime Minister and Minister Reti to the exit, where the cars will be waiting in the coned off area.	

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Appendix 2 – Media Release

2 April 2024

Prime Minister and Health Minister lead from the front as flu season approaches

Prime Minister Rt hon. Christopher Luxon and Minister of Health Dr Shane Reti have rolled up their sleeves to get this year’s flu campaign underway, receiving their flu vaccinations at The Fono clinic in Auckland.

From today (April 2), flu vaccinations are available free of charge for people aged 65 and over, pregnant people and those most likely to get very sick with the flu. Eligible groups can get their free flu vaccination from their local pharmacy, doctor, nurse or healthcare provider.

“Influenza and other respiratory illnesses do have a massive impact on the health system over winter and we can do more to prevent this by taking action now, by getting vaccinated, preparing our homes and having a plan to help stay well through the colder months,” said Dr Reti.

Hospitals often have an increase in admissions over winter, due to respiratory infections and other illnesses spreading easily as people spend more time indoors.

“This is also a good time for families to be checking if their children’s immunisations are up to date, particularly MMR. We know the harm measles has on communities but it’s a disease which can be prevented with immunisation,” Dr Reti added.

Immunisation records can be accessed on My Health Record (my.health.nz) or by speaking to your healthcare provider.

Dr Reti said there are many other ways communities can prepare for winter to ensure they stay well over that period.

“Preparing our homes to protect from cold and damp conditions is good to do now whilst it’s still a bit warmer. It’s also helpful to ensure we have care plans for any vulnerable family members and remember to stay home if you are unwell to avoid spreading illnesses."

The Healthy Homes initiative provides free support for eligible groups to make their homes warm, dry and healthy. This includes help with curtains, beds and bedding, accessing insulation, minor repairs, ventilation, heating sources and a range of other support.

Those who are eligible include pregnant people, low-income families with children aged between 0 and 5 who have been hospitalised with a specified housing-related condition, and families with children between 0 and 5 who have at least two of the social investment risk factors.

ENDS

Notes:
The flu vaccine is free for people at higher risk of getting very sick from the flu including:

- people aged 65 years and over

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- people who have a long-term medical condition like diabetes, asthma, or a heart condition (ages 6 months+)
- pregnant people
- children aged 4 years and under who have been hospitalised for respiratory illness or have a history of significant respiratory illness
- people with mental health conditions, including schizophrenia, major depressive disorder, bipolar disorder, or schizoaffective disorder
- people who are currently accessing secondary or tertiary mental health and addict on services.

Further information about the Healthy Homes initiative, including details for local providers, is available at Healthy Homes Initiative – Health New Zealand | Te Whatu Ora

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Appendix 3 –Q and As

Immunisations

Why don't you make the flu vaccine free for everyone?

- Pharmac operates on a fixed budget and has to make difficult choices about which medicines are funded. For those who do not meet the funded eligibility criteria the flu vaccine is available through private immunisation providers (Māori and Pacific hauora healthcare providers, general practitioners, pharmac sts or occupational health) at a small cost.

What are the different types of flu vaccinations available?

- The funded flu vaccine for children and adults (6 months of age and over) available in New Zealand, Influvac Tetra. This vaccine has been developed to protect against the flu strains that have been identified by the World Health Organization this year. Pharmac funds the vaccines and determines who is eligible.
- While each flu vaccine offered in New Zealand is s ightly different, they are all approved by Medsafe and can help stop you from ge ting very sick if you do catch the flu. Being vaccinated provides you with the best possible protection against flu symptoms, so it's important that you get a flu vaccine, whether you opt for the funded or non-funded vaccine.
- There are unfunded alternatives available that may provide an individual with better protection It is recommended that you talk to your healthcare provider if you have questions about the different flu vaccines that are available.

Can people get the flu vacc nation at the same time as other vaccinations?

- The flu vaccine can usually be given at the same time as other vaccines including all vaccines on the National Immunisation Schedule.

What happens if people get sick with the flu and COVID-19 at the same time?

- Flu and/or COVID-19 can cause hospitalisation and sometimes death in the most vulnerable people. The risk of contracting them together could be more severe for those most vulnerable.
- Having both the COVID-19 and flu vaccines protects a person from the more serious health consequences of COVID-19 and the flu.

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Are you concerned about the impact of illness on our health system this winter?

- We do generally see an increase in illness and hospitalisations over the winter period.
- In particular, we tend to see an increase in hospitalisations for flu and COVID-19, which is why it's really important to get both these immunisations ahead of winter

What are you doing to prepare the health system for winter?

- Encouraging immunisations across the community is a really important part of preventing a large impact on the health sector over winter. This is because the flu vaccine can prevent the illness from becoming more severe, which means fewer people need to end up in hospital.
- Immunising our workforce is also a really important part of this. We currently have an immunisation campaign underway for health staff, which helps to prevent them from having to take extended time off sick.
- We also have our Healthy Homes initiative, which helps eligible families with young children to make their homes wa m and dry. This helps to prevent them from getting ill and ending up in hospital too, with things like rheumatic fever.
- Our hospitals also undertake a range of activity to prepare for any winter surges, and constantly monitor capaci y. One of the advantages of having one health system now is that we can now allocate resources based on where we are seeing particular need.
- We know that GPs can also get really busy over winter, so our Healthline service is also an important part of the winter response. This is a free number that people can call or initial health advice. Pharmacies are also a good avenue for advice on minor ailments.

When will pharmacies start to offer childhood immunisations?

- Pharmacies that wish to offer childhood immunisations will be able to order the vaccines once they have completed the required training to vaccinate this age group. It's an optional service that pharmacies can offer to help support whānau to access free vaccines for their children if they cannot make it to their GP or if pēpi is not yet enrolled. Pharmacists have been asked to enquire whether whānau have a GP and if not, will help support connecting them to one. General practice will remain the preferred place for childhood immunisations to be administered as there are important medical checks that also take place during these visits.

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- [Background: Training was made available for pharmacist vaccinators to upskill to authorised vaccinators from 27 March and the vaccines can be ordered from 1 April once they have been confirmed to have met the site requirements, e.g., having a separate room for immunisations to take place. The training can take several weeks so it is anticipated that there will not be a high uptake of pharmacies offering this service within in the first month].

Winter

What are you doing to ensure that hospitals aren't overrun during winter/flu season

- Every winter, hospitals and the healthcare system see an increase in admissions fo respiratory infections and other illnesses associated with the season
- Preventing hospital admissions and ensuring timely hospital discharges is key to freeing up long stays and beds.
- Districts are working to improve admission and discharge processes for older people, especially those with complex needs, by arranging acute care in the community, where needed, along wi h in-home trea ment and support from a range of health professionals.
- We're working towards ensuring planned care delivery continues under system pressure e.g., maximising use of theatres and private capacity.
- A new theatre dashboard providing national visibility of capacity and demand is giving us bet er information to make informed improvements to theatre use.

Are you expecting this winter to be busier than last year?

- The winter months are typically the busiest for health care services and choosing the ight type of care can help ease pressures right across the system.
- We always prioritise care so that those who need urgent care will be seen quicker than th se with less serious illnesses.
- For those with non-critical illnesses or injuries, there are other options available. For example, people can see their GP or call Healthline (0800 611 116) for free health advice from a registered nurse. If your child or baby is unwell, you can call Plunketline 24/7 for advice on 0800 933 922.

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- Please remember that anyone who does need urgent, or emergency care should come to ED without delay or call 111. Our ED remains open 24/7, 365 days a year, and we do not turn anyone away who is seeking medical help.

What will you do to manage workforce pressures over winter?

- Our workforce is no different to any other workforce. Our staff are part of the community, and they too get sick. We manage workforce absences daily and there are good systems in place to manage workforce pressures within our hospitals and across the health system.
- We have recently announced a number of additions to our workforce, with 543 new doctors (house officers) joining Health New Zealand in January.
- We are seeing strong growth in our Health New Zealand nursing workforce. The latest data available (September 2023) shows that we have around 28,000 nursing FTEs across Health New Zealand. This number has risen by 900 since the previous quarter and almost 2,000 compared to September 2022.
- We are still waiting on data on nursing vacancies for March 2024, which will capture new nursing graduates who started n January; we expect it to be released by July this year. However, frontline intelligence suggests that we have filled many generalist nursing vacancies, however we recognise there is still pressure in some specialist areas, including for mental health and addic ions services and critical care nurses.

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Aide Memoire

Māori Health Pipeline: An Evidenced Based Approach to Reducing the Life Expectancy Gap for Māori

To:	Hon Dr Shane Reti, Minister of Health	Reference:	HNZ00040256
From:	Dr Dale Bramley, National Director, Service Improvement and Innovation, Health New Zealand – Te Whatu Ora	Due Date:	22 March 2024
Copy to:		Security level:	In Confidence

Contact for telephone discussion (if required)			
Name	Position	Telephone	1st contact
Dr Dale Bramley	National Director, Service Improvement and Innovation	S 9(2)(a)	x
Dr Karen Bartholomew	Director Health Equity, Service Improvement and Innovation		

Attachments
Appendix 1: The 5-step method used in the Māori Health Pipeline
Appendix 2: Key disease drivers of the life expectancy gap

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Purpose

1. As we head into a new phase for hauora Māori, we wanted to provide you with information on part of our existing work programme to better deliver for Māori - what we call our 'Māori health pipeline'. This Aide Memoire also builds on recent deep dives to understand performance and planned improvements, such as related to lung cancer screening which is an important part of the pipeline.

2. The pipeline is a collection of evidence-based projects to enhance the effectiveness of services for Māori, including to reduce the life expectancy gap. Alongside wider work for hauora Māori, we will continue to build this initiative, further pushing our performance to reduce inequities and improve outcomes for Māori.

Summary

3. The Pipeline is an evidence-based programme of work dedicated to informing funding for investment in areas of high impact for Māori health gain, and informing policy in specific areas such as screening.

4. The programme enables testing specific proof-of-concepts or prototypes, and then scaling up successful and cost-effective interventions to address specific inequities – the mortality condition drivers of the life expectancy gap. Most intervention focus on cancer, cardiovascular or respiratory disease (which are key drive s o mortality overall, and for sex-specific, socioeconomic and geographic life expectancy gaps).

5. The Pipeline has developed a 5-step method; outlining the key steps to scale-up or nationalisation (see Appendix 1). This approach draws on, and is a igned to, similar approaches used in an innovation scale up and research knowledge translation (implementation science).

6. The Pipeline programme includes the following:
   - Lung cancer screening – ongoing trials and national plann ng
   - Abdominal Aortic Aneurysm (AAA) and Atrial Fibrillation (AF) screening – ongoing trials and national planning
   - HPV self-testing for cervical screening – alternative models to primary care aligned to the future Nationa Cervical Screening Programme (NCSP) intentions and Parliamentary Review Committee recommendations
   - Hepatitis C – lookback programme nearly complete, now prototyping a future national support and treatment service and national planning for general population screening approaches
   - Endometrial Cancer development of a screening test (microbiome study), this project also has a Pacific focus
   - In a related project, focused on Pacific and Māori health, undertaking a Rheumatic Heart Disease (RHD) Echo screening – comparison of two models of care for programme de ivery, including school-based screening.

7. The Pipeline programmes focus on screening/early-detection and model-of-care innovation (precision prevention). This includes testing the safe and optimal use of alternative workforces (e g. the Abdominal Aortic Aneurysm (AAA) screener role and whānau engagement coordinators).

8. Pipeline programmes take a rigorous approach, focusing on what evidence matters for a New Zealand context and what matters for successful implementation.

9. Scale up and nationalisation includes a specific focus with the receiving services to ensure that any planning and business case development is undertaken collaboratively and with full visibility (for example with the National Public Health Service, the Cancer Control Agency – Te Aho o te Kahu, the Public Health Agency).

10. The Pipeline programme has a track record of publication and impact on policy/programmes decisions (for example the decision to change to HPV self-testing in the change to HPV primary screening for cervical cancer), of high impact partnerships (eg with universities, researchers, clinicians across the country and internationally eg Mayo clinic), and of successful receipt of high impact research funding (approximately $12m to date).

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11. The programme demonstrates value in a number of ways including clinical screening benefits to participants, programme/policy impacts, as well as undertaking health economic assessments of the programme interventions. Model of care innovations seek to improve programme reach, efficiency or outcomes which are also components of value.

Background / context

12. The Māori Health Pipeline is a programme developed under Commissioning init ally in the Waitematā and Auckland | Te Toka Tumai areas with subsequ nt expansion to the Northern Region. The programme now sits in Service Improvement and Innovation, with a focus across the whole country.

13. The Pipeline contains initiatives to accelerate projects that address inequities in life expectancy and/or have significant potential for Māori health gain. The pro ects have been underway since 2014 – organised formally into the ipeline since 2016

14. A number of small and large scale projects were completed under the Pipeline, and the programme evolved and expanded under Kōtui Hauora, the then Iwi-DHB Māori Partnership Board. Completed projects include a large scale breast screening datamatch that contributed to the successful funding of a new population register for breast screening, and a cardiac rehabilitation alternative model of care project.

15. The Pipeline has been focused on sc eening and early detection at the request of the original joint DHB-Iwi Northern Governance Board at the time. It has mostly excluded work on child health, mental health and diabetes as here were substantial programmes of work and investment in these areas in Commissioning at the time and the DHB-Iwi Governance Board reques ed the Pipeline resources to be directed at the areas they perceived had gaps. With the evolution of the Pipeline over recent years this has shifted – with the first ch ld focused project commencing in 2023 (RHD Echo Screening), and with point-of care (POCT) diabetes testing included in the Abdominal Aortic Aneurysm (AAA) Programme.

16. The key d vers of the life expectancy Gap for Māori are provided in Appendix 2, and the areas addressed in the Pipeline programme are highlighted on the 'top 10 drivers' table.

17. Scoping potential new candidate conditions/interventions is also undertaken regularly (Step one of the 5-step method). A piece of work on consideration of Chronic Kidney Disease sc eening has just been completed (there is insufficient evidence to proceed with screening non-diabetics, and screening for diabetics is generally well completed – however a focus on linkage to appropriate treatments has been referred to the national diabetes planning work). The current scoping work is focused on potential options for *H. pylori* screening for stomach cancer.

18. Screening related work is undertaken using the National Screening Advisory Committee (NSAC) approach of the eight screening criteria used for assessing new programmes or significant programme changes. This includes assessment of the evidence of intervention effectiveness, cost and cost-effectiveness, workforce, social and ethical considerations. The Pipeline programme seeks actively to undertake research to complete any evidence gaps, for example the updated cost-effectiveness analysis for lung cancer screening. Where it may inform policy considerations this

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work is also undertaken alongside the relevant parts of screening policy including the Public Health Agency, NPHS and the Cancer Control Agency | Te Aho o te Kahu.

Discussion

19. Further detail on the key Pipeline projects, their impacts and next steps are provided in Table 1 below.
20. Further detail is provided after Table 1 on the two largest programmes, lung cancer screening and AAA/AF, which are now undertaking coordination of business case development for potential future national programmes.

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Table 1. Projects in the Pipeline

Programme	Rationale for focus	Intervention	Studies/projects	Commentary
1. Lung cancer screening	• Leading cancer cause of death for total population and Māori (~20% all cancers) • Biggest contributor to life expectancy gap by far • Incidence and mortality 3-4x higher for Māori, and get lung cancer ~6-8 years earlier	Targeted Low dose CT chest for smokers/ex-smokers	• Cost-effectiveness analysis – complete • Survey/focus groups to inform programme development – complete • Trial of invitation methods (comparing primary care to central hub – 504 scans) – complete • Cohort study including spirometry for COPD – nearly complete • Optimising a New Zealand risk prediction model for eligibility – commenced ~1200 scans	• Large scale partnership with University of Otago (Professor Sue Crengle is the Principal Investigator) • Under Professor Crengle, have secured HRC and other research funding (three grants) and related National Science Challenge grant • Substantial international partnerships (UK, Australia, Canada) • Demonstrated cost-effectiveness in New Zealand • To date 92% consent to CT, ~2.5% cancer detection (80% early stage)
2. AAA/AF screening	• Part of cardiovascular conditions, top cause of mortality for total population and Māori, is a key driver of inequities in life expectancy gap for men overall • Māori more likely to develop AAA and die from a rupture,have AAA ~8 years earlier • Māori women also at high risk due to smoking prevalence • Māori more likely to have a stroke, especially younger and more disabling, less	Single (once-in-a-lifetime) limited view abdominal ultrasound Portable ECG detector Point of care bloods and CVD risk assessment Includes smoking cessation and BP check Includes consent to check up to date with other national cancer	• Completing the final research projects in 2024-25 (12 projects to date) • Implementation in community urban settings (metro Auckland) Māori – complete • Prediction model testing – non-Māori - complete • Pilot x3 in rural settings (Northland – Te Tai Tokerau) – complete • Pacific men – complete • Pacific women – will be complete in 2024 • Next project in Wellington from mid-March 2024 focus is using biomarkers to determine eligibility and focused on point of care blood tests – working closely with Universities of Auckland and Otago	• Only place in world to proposescreening women in a programme • Screened ~4700 people to date, prevalence ~2-3% (cost effective intervention at 1%), new AF detection ~1-2% (stroke prevention focus • Wellington site and last projects in 2024 will screen an additional ~2000 people • Addition of point of care bloods with a CVD risk assessment, and a check to see if other national cancer screening is up to date – efficient approach • Could use same epigenetic marker to determine eligibility as lung cancer screening (could be a world first) • Has been partly research funded (HRC)

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Programme	Rationale for focus	Intervention	Studies/projects	Commentary
	likely to get medications for AF to prevent stroke	screening programmes		

3. HPV self-testing	• One of the most preventable cancers
	• Cancers occur in those overdue/ never screened – improving access to the test and follow up is the key (this project tests these approaches)
	• Māori higher incidence and more likely to be overdue/ never screened
	• We already know self-testing works for everyone including Māori, now is about how best to access and follow up other than primary care
	• Model of care innovations and demonstrating what works
		HPV self-test for cervical screening
		
		Telehealth, call centre, coordination hub, intensive support for follow up
		
		Large mail-out project
			• Feasibility study – complete
			• Trial comparing mail-out to clinic – complete ~3,500 women
			• COVID contactless pilot – complete
			• Implementation science study – nearly complete (funded by Ministry of Health to directly inform the implementation of primary HPV screening which it has done) – tested 3 pathways:
			  ○ Clinic-based
			  ○ Telehealth/mail-out
			  ○ Community
			• Planned work to expand integration with other screening programmes (eg breast screening), pharmacies and inform planning work on mail-out that the National Public Health Service (NPHS) National Cervical Screening Programme (NCSP) is leading
				• Self-tested ~6,600 women in current study to date, positivity ~10%, follow up for positive tests 98%
				• Primary care research has helped inform the roll-out of the new HPV programme
				• Current project focused on non-primary care settings: telehealth, mail-out, no-touch options (electronic consent, self-serve), and community settings (eg pharmacy, workplaces) – prototypes with nurse-led oversight
				• First and only project to look at telehealth and mailed self-test kits in New Zealand, contacted ~26,000 women in recent project
				• Partly research funded
				• Further scope to investigate access related to other under-screened groups eg older women, high BMI, disability, rural
				• Further scope to support NPHS investigate specific aspects of a community model-of-care (Parliamentary Review Committee recommendation)

4. Hepatitis C	• Causes 25% liver cancers • Māori higher burden of disease • Almost totally preventable cancer with new easy to take oral medication (Maviret®)	Intensive wrap-around support for treatment for those with a positive Hep C test (telehealth) Testing the feasibility of	• Lookback project – nearly complete (offer of treatment to all in Northern Region tested in last 10 years with no record of medication) • Support and Treatment prototype to get people on treatment (linked to care) – prototyping what might	• Treatment results in cure and is vastly cost-effective • Avoiding future liver cancer, failure, transplant • Team have made ~4,500 contacts to date in the lookback

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Programme	Rationale for focus	Intervention	Studies/projects	Commentary
	• Access to testing in the community with follow up is the key (this project tests these approaches) • National screening programme will be required to eliminate Hep C (and Hep C inequities) • Testing potential models of national screening including in ED and in community laboratories	approaches for a national screening programme	be required for a national linkage to care programme and an essential service for a national screening programme • Feasibility study in community laboratories to add blood test when already attending • Undertaking due diligence work on consent model for ED screening, likely to test different models of verbal consent similar to the community laboratory study • Also supporting the national modelling - approx 20,000 people in NZ with Hep C who do not know it yet (and targeted testing will only reach ~40%)	• National screening approach under consideration – testing the feasibility of potential highly efficient models • Working with local NPHS, and with Public Health Agency, including on consideration of requirements for a register • NSAC have provided an initial supportive assessment of general population screening, awaiting further research results
5. Endometrial cancer	• Incidence and mortality for endometrial cancer rising steeply (unlike any other cancer) • Pacific women have highest rates of endometrial cancer in the world, Māori women also higher • Pacific and Māori women more likely to be young (~45-50) and pre-menopausal	Swab for bacteria in microbiome identified as potential cancer causing agent (*Porphyromonas somerae*)	• Trial with Mayo clinic support to determine whether same bacterial profile found in New Zealand women (microbiome study) • Qualitative study underway • Datamatch of endometrial cancer cases to determine drivers of the rise of incidence and mortality (project working with the Cancer Control Agency – Te Aho o te Kahu)	• Potential that could lead to a new screening test – New Zealand could be first in the world to develop this approach • Microbiome study will test ~260 women • Currently hold three research grants from the Health Research Council (HRC) and the Auckland Medical Research Foundation (AMRF) for ~$350k • Will support Cancer Control Agency Te Aho o te Kahu and Pacific Health Group broader focus on Endometrial Cancer
6. Rheumatic Heart Disease	• Evidence that RHD is under diagnosed and can reduce progression and other issues (eg	Targeted limited view cardiac screening echo for children/	• Evaluation of two pilot sites including cost-effectiveness • Evaluation of different intervention models	• Part of Rheumatic Fever Roadmap • Commissioning funded • Planning currently – school based initial focus

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Programme	Rationale for focus	Intervention	Studies/projects	Commentary
Echo screening	cardiac surgery, maternal mortality, early death) by early diagnosis and treatment • Progressive condition can be prevented with access to bicillin programme once detected	adolescents (school and siblings)		• Nurse echo workforce development (will include with AAA screener role in national workforce discussions – potentially aligned track)

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Lung Cancer Screening

21. Lung cancer is a significant issue for both Māori and non-Māori; in 2017 lung cancer was the 4th most common cancer and the leading cause of cancer death in New Zealand.

22. Lung cancer is a major source of health inequity for Māori and is the leading cause of cancer death. In addition:
    - Māori women's rates of lung cancer are over four times those of non-Māori, and in Māori men the rate is nearly three times higher than in non-Māori
    - Māori develop lung cancer around six years earlier than n n-Māori, and at lower recorded smoking exposures.
    - Māori have approximately 30% higher mortality when diagnosed with cancer, due to a range of factors including comorbidities, later diagnosis, and acces barriers.

23. Lung cancer is the single largest contributor to the dif erence in life expectancy between Māori and non-Māori. Māori have the highest lung cancer incidence and mortality and rates of lung cancer.

24. Lung cancer survival in New Zealand is worse than in other comparable countries.

25. Lung cancer rates are strongly associated with levels of socioeconomic deprivation; however, socioeconomic status and recorded smoking rates do not fully explain the inequitable outcomes in lung can er for Māori. It is likely that true smoking exposure is poorly captured in routinely recorded smoking da a.

Lung cancer screening reduces mortality

26. Screening for lung cancer offers the potential for early detection of disease, where treatment options would offer a better chan e of survival. Screening generates a stage shift from 70% late stage at diagnosis to ~70-80% early stage at diagnosis.

27. The effectiveness of lung cancer screening is established. Two large trials, the US National ung Screening Trial (NLST) and the Netherlands / Belgium NELSON trial have provided high quality international evidence showing that early detection through low dose CT scan (LDCT) screening of asymptomatic people at high-risk of ung cancer reduces lung cancer mortality by more than 20%, and this reduction is even higher for women (39%).

28. A meta-analys s of these and seven other smaller trials concluded that LDCT screening is associated with a significant reduction in LC mortality.

Other comparable countries are investing in lung cancer screening

29. The US Canada, the UK and recently Australia either have established screening programmes or are in the process of establishing screening programmes. There is a strong international policy network with collected lessons learned and guidance available for countries considering implementing lung cancer screening.

30. Australia recently announced investment in a national lung cancer screening programme, including mobile CT scanners for remote areas, and has outlined a $260m programme establishment phase.

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31. The team have strong links into international programmes, including directly into the planning work in Australia.

New Zealand research programme: Te Oranga Pūkahukahu

32. Internationally, there are no current screening programmes which are equity focused or include sufficient representation of Indigenous people, despite the burden of disease in these communities. Given the disparities in lung cancer rates in New Zealand, it is important to design a screening programme that is accessible and addresses Māori needs.

33. Te Oranga Pūkahukahu is a Māori-led approach to answering policy relevant questions about lung cancer screening in New Zealand. The progr mme is a partnership with University of Otago and is led by Professor Dr Sue Crengle as the Principal Investigator.

34. The research programme has undergone thorough consultation with Māori experts and whānau Māori and works closely with a study adviso y group made up of people who would be eligible for or have undergone lung cancer screening and their whānau (consumers with lived experience).

35. The research programme is funded by the Health Research Council (HRC), The Cancer Control Agency - Te Aho o te Kahu, and the Ministry of Health and the operations are supported in Service Improvement and Innovation by Health New Zealand – Te Whatu Ora.

36. The research programme has relationships with various Iwi-Māori Partnership Boards (IMPBs) and Māori providers who are interested in support and helping design the programme.

37. The research programme has number of projects within it, outlined below:

Cost-effectiveness analysis

38. This demonstrated that lung cancer screening would be cost effective in all population groups in New Zealand but especially for Māori and most particularly for Māori women who currently have the poorest survival rates.

39. Complete and published with high impact.

Survey/focus groups

40. Series of focus groups and surveys sought to understand Māori perspectives of lung cancer screening which showed very high support for a programme (91% participants said they would attend screening). Participants identified a range of barriers to screening, which included stigma around smoking status, previous negative experiences in the health care system and barriers to access.

41. Complete, papers due out for publication very shortly.

Trial of invitation methods (comparing primary care to central hub)

42. Based on the survey finding in 2022 a Randomised Controlled Trial commenced comparing a primary care-based invitation model (like cervical screening) with a central hub model (like breast or bowel screening).

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43. This study is Māori-focused and is now and complete with 504 CT scans and more than 1000 risk assessments completed on eligible participants. Overall the study found that approximately half of the participants risk assessed were at high enough risk to be offered a CT scan, and that there was a very high consent rate for a CT scan (92%). Twelve lung cancers have been detected (~2.5% detection rate), very similar to the rates seen in the overseas trials.

44. Results have recently been presented at an international cancer conference in Melbourne and publication is underway.

Cohort study of spirometry for COPD

45. This study investigated the potential of co-benefits of lung cancer s reening – specifically whether it was feasible and acceptable to conduct COPD assessment alongside a lung cancer screening scan.

46. Spirometry assessment performed to test for COPD on more than 200 participants n the invitation study.

47. The study is complete and results are now being analysed.

Optimising a New Zealand risk prediction model for eligibility

48. The next major phase of work just commenced is a Risk Prediction Study, a mixed methods study across the whole of the Northern region including rural and remote areas of Northland – Te Tai Tokerau and Counties Manukau. Approximately 1200 people (Māori and non-Māori) will receive a CT scan.

49. This study will optimise New Zealand specific risk pr diction parameters, working closely with the Canadian ead author of the original risk prediction model Professor Martin Tammamagi. Given the incidence and mortality profile is so different than elsewhere, it is important to test and refine the parameters using local data.

50. The study will also test electronic self risk assessment, a novel voucher referral mechanism, and Māori provider support for screening. The two northern IMPBs support this study.

51. The cost effectiveness assessment will be updated using data from this study.

Future research

52. An application to the HRC for a Programme Grant (5 years, $5m) to continue examining key policy relevant questions has been made. Proposed projects include the use of blood biomarkers, foundational work in artificial intelligence, incidence round CT scans to examine interval cancers, and further programme development with Māori Providers (supported by the IMPB in the Manawatū).

Planning for a National Lung Cancer Screening Programme

53. Given the strong evidence and informed by the research programme outlined above, the next national cancer screening programme is likely to be lung cancer screening.

54. The National Screening Advisory Committee (NSAC) regularly consider the research progress, and will formally consider approval of the programme in the near future.

55. Service Improvement and Innovation are coordinating national planning (including business case development) for lung cancer screening, including the relevant parts

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of Health New Zealand and relevant agencies: the National Public Health Service, Hospital & Specialist Services, Commissioning (including primary care), with the Cancer Control Agency – Te Aho o te Kahu, and the Public Health Agency (Ministry of Health).

56. National planning includes input from key clinical networks and clinical groups (radiology, oncology, respiratory, primary care), as well as consumers.

57. The work is sponsored by Dr Dale Bramley with Professor Sue Crengle and is supported by an Oversight Group and eight working groups. The Oversight Group was initiated in February 2024.

58. An indicative business case is anticipated in December 2024.

AAA/AF Screening

59. Abdominal aortic aneurysm (AAA) is a disease in which the main artery in the abdomen balloons out and, if it becomes large enough, can burst, usually with fatal consequences, unless it is repaired surgically (most often endovascu ar repair).

60. AAA occurs about 8 years earlier for Māori, a d Māori are more likely to die if a AAA ruptures. The main risk factor for AAA, like all cardiovascular diseases, is smoking.

AAA screening reduces mortality and is cost-effective

61. Large randomised trials in the UK and Europe have demonstrated that it is possible to reduce mortality from AAA through once-in-a-life ime abdominal ultrasound screening of the aorta.

62. International and NZ studies have also found AAA screening to be cost effective in at-risk populations at about a prevalence of 1%.

AAA/AF research programme

63. A pilot project o sc een for AAA in eligible Māori was conducted in Waitematā and Auckland districts from 2016-2018

64. A specific technical role (AAA s reener) was trained, rather than drawing on the overstretched ultrasonography workforce. They undertake limited aortic views only, therefore have very low incidental findings.

65. AAA screener training was based on the UK model, and includes radiologist oversight and quality assurance. The local vascular service consider the scans completed by the AAA screener to be such good quality that they are used diagnostically (no confirmatory scan required) ahead of surgery.

66. The ultrasound machine used in the programme is portable, and scanning is undertaken in various community venues (primary care, community halls, marae).

67. The pilot found that Māori men had a prevalence of AAA (at ~3%) more than double that of the men who participated in the UK and Swedish screening programmes. It also found that Māori women had a high prevalence (~2%).

68. The project has been subsequently rolled out, answering specific policy-relevant questions. Overall the research programme has conducted 12 projects and screened more than 4700 participants (Māori, Pacific and European).

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69. The programme tested a risk prediction algorithm, but found that smoking was essentially the main factor driving AAA risk so this was not taken forward. This is being written up for publication currently.

70. The programme includes resourced active follow-up to ensure connection to primary and secondary services for any positive screen results, including strong relationships with vascular services.

Including AF screening

71. As the research programme was extended screening for Atrial Fibrillation (AF, an irregular heart rhythm and important risk factor for stroke) and high blood pressure, as well as referral for smoking cessation, were included in the screening session.

72. AF screening is not currently recommended by NSAC due to awaiting international evidence of the effectiveness at a population level in stroke eduction. However, there is a higher prevalence of AF and of younger stroke in Māori and Pacific, and there is known underdiagnosis and suboptimal medicatio use.

73. AF screening is conducted using a small handheld smartphone devic AF screening was incorporated as it is simple, and to prompt best practice management of AF (anticoagulation medication).

74. An audit of AF screening in the programme has just been published and demonstrated 1.2% prevalence of newly diagnosed AF with referral for anticoagulation, and also improved anticoagulation for already known AF from 57% to 83%.

Including POCT and CVD risk assessment

75. HRC funded a recently completed study in Northland – Te Tai Tokerau assessing potential co-benefit health nterventions in a AAA screening session, given the rural setting and access barriers to prevention and primary care.

76. Surveys, focus groups, community hui and health professions interviews were conducted. There was very strong support for other health interventions, particularly prevention and heart related tests, and point-of-care blood tests (POCT).

77. Based on these findings a further Northland pilot was conducted offering POCT blood ests (cholesterol and diabetes tests, and a heart failure test), updating a CVD risk assessment score, and returning these results to primary care. Additional research bloods were also taken. More than 97% of participants agreed to POCT, and reported ve y positive experience in receiving their results at the session.

78. The team are also testing whether people wish to have their screening status checked for the national cancer screening programmes, and supported to link with the programmes to get screened. This has been well received, and the positive experience at AAA screening supports engagement with other screening and health interventions.

Future research

79. The study assessing prevalence in Pacific women will be complete in mid-2024.

80. Two further studies will be conducted in 2024-2025 – one has recently commenced in Wellington, screening a further 2000 people in total.

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Planning for a national AAA screening programme

81. NSAC approved a national AAA programme for men in 2018, however there was not capacity to take this forward by the Ministry of Health or sector at the time.
82. NSAC receive regular progress updates on the research, and will consider the evidence on including women in a national programme in the near future.
83. At the Vascular Society conference in March 2024 a call to support development o a business case for AAA screening was made, with good clinical support. Service Improvement and Innovation are coordinating this national planning, informed by the research, with the relevant parts of the system similar to the approach for lung cancer screening.
84. A key consideration of AAA national planning is the AAA sc eener workforce pathway, and the programme taking on surveillance scanning for ectasia. Regional vascular services are developing and these, alongside the key clinical networks wil be critical to the national planning work.
85. Options for national planning will include consideration of the broader preventative intervention suite undertaken with strong succes in the research programme.

Next steps

86. The 5-step method ensures a robust evidence-based approach to addressing key condition drivers of the life expectancy gap.
87. High impact, policy-relevant, research programmes a e being scaled up to improve outcomes, and are being progressed through the relevant decision making steps as national prevention programmes which will contribute to improved health outcomes for New Zealanders.

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Appendix 1

Māori Health Pipeline 5-step method

1. Scoping and start-up	2. Prototype	3. Settings or comparisons	4. Scale-up	5. Nationalisation / handover to receiving service
• Concept description • Understanding inequities and their drivers • Literature review • Intervention clarification • Undertake preparatory work eg participatory approaches with potentially eligible participants and whānau	• Testing the intervention in a research context • Prevalence • Basic / clinical research (efficacy or effectiveness) • Adaptation or localisation to NZ setting • Feasibility / acceptability	• Implementation science research • Test in specific populations eg ethnic groups or settings eg rural • Test in specific models of care eg community provider, central hub, nurse-led • Test against specific comparator groups eg RCT	• Implementation science research • For established interventions testing programme requirements eg workforce, IT, clinical pathways, co-benefits • May aim to reach 5-10% of the eligible population if a priority for nationalisation	• Planning work with the receiving service(s) • Informing business case • Aligning priorities, expectations, timeframes, budget • Pipeline may 'hold' some service activity over this time until transition to a service/ programme

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Appendix 2

Top ten causes of death contributing to the life expectancy gap for Māori

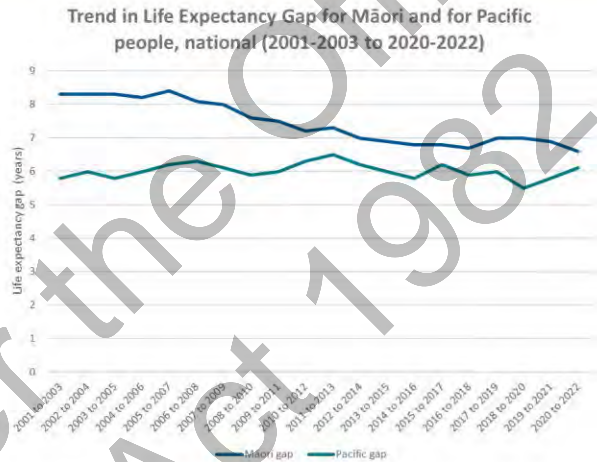
Life expectancy gap – disaggregation - Māori

The top ten leading avoidable causes of death contributing to the life expectancy gap for Māori – Northern Region (contribute 3.8 years of the 8.3 year gap) 2018-2020

Avoidable cause	Contribution (years)
Coronary disease	0.9
Lung cancer	0.9
Diabetes	0.4
COPD	0.4
Land transport injuries	0.3
Suicide	0.3
Other accidental injuries	0.2
Stroke	0.2
Valvular heart disease	0.1
Stomach Cancer	0.1

Primary focus of Pipeline programme (yellow star): Lung cancer, Valvular heart disease

Secondary focus in Pipeline project (orange star): Coronary disease, Diabetes, COPD, Stroke



NMNP=Non Māori, Non-Pacific

Source: M Walsh, LE Gap analysis, Equity team SII 2023

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