Quarterly Performance Report

Quarter ending 30 September 2022

Te Kāwanatanga o Aotearoa
New Zealand Government

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Te Whatu Ora
Health New Zealand

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Introduction

This is the first Quarterly Report by Te Whatu Ora – Health New Zealand entity, created on 1 July 2022, covering the period 1 July to 30 September 2022. It reflects the integration of 28 separate entities into a single organisation – the largest in Aotearoa New Zealand.

The key objective during this period was to maintain continuity of services for the public.

The reporting period covers the first steps in the transition to a new hauora system, taking direction from *Te Pae Tata – the interim New Zealand Health Plan 2022 (Te Pae Tata).*

This report reflects a health system that is experiencing a range of delivery challenges as we move through COVID-19 peaks.

Aotearoa's health system is in a better position than that of other jurisdictions and this is evidenced in the recent report prepared by the Health Quality and Safety Commission However, we acknowledge that compounding factors of increasing demand and lengths of stay, reduced primary care and community capacity and workforce fatigue are likely to continue in the short term, while we work on a range of initiatives to arrest the trends. These initiatives include working with immigration and education agencies to increase the number of people in our health workforce, increasing the numbers of people accessing cancer screening tests, improving vaccination rates especially in Māori and Pacific people, and improving the national mental health programme.

Improving equity of health outcomes for Māori and Pacific people and Tangata whaikaha | disabled people lies at the heart of our mahi. This includes honouring the three articles of Te Tiriti o Waitangi to enable whānau to live healthier lives. We are working in partnership with Te Aka Whai Ora – the Māori Health Authority to embed Te Tiriti o Waitangi into all our core functions. We have also begun working with over 30 iwi across Aotearoa to build localities - supporting local solutions to health issues that work for local people. The importance of this work is underscored by the continued poorer outcomes, reflected in the statistics, for Māori across a wide range of key metrics including immunisations, diabetes complications and access to healthcare.

The health workforce continues to face pressure from the ongoing impact of COVID-19 and other factors such as global health worker shortages. This report highlights early work with the education and training sector to grow our health workforce, alongside significant new initiatives announced to expedite immigration pathways for overseas trained health professionals. To support the transition to a new inclusive health workforce, engagement with our health sector workforce and with our union partners on Te Mauri o Rongo | the Health Charter has recommenced.

The results of a combined national view highlights systemic challenges. The national view is increasingly available for hospital services but not yet available for primary and community care. The development of nationally aggregated data for non-hospital-based services is a key focus for development over the coming months.

The report covers financial sustainability, which shows Te Whatu Ora is within budget for 2022/23.

Key digital and infrastructure programmes have continued with $1.821 billion of actual capital project expenditure incurred at 31 August 2022. This is against the 103 capital projects managed by our infrastructure team including building new hospitals and refurbishing health infrastructure across the motu.

The report notes the work underway on laying the foundations for the future of our health sector, including the permanent appointment of all our national delivery directors and the actions underway to improve environmental sustainability and climate resilience.

This report provides a snapshot of current focus, challenges and performance in the first three months of operation and outlines the further work needed to develop a more comprehensive and real-time picture of health system performance, and track and monitor how we are delivering against our performance measures. Progress building on our current state will be reflected in the Quarter 2 report and each subsequent report thereafter.

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How to read this report

This report provides a high-level overview of health system performance for the first quarter of operation, the period from 1 July to 30 September 2022. It takes as its starting point the targets set for health through the interim Government Policy Statement and is largely organised along those lines. Where applicable, it also incorporates other health measures and targets including previous Health System Indicators, and metrics set out in the Statement of Intent/Statement of Performance Expectations and initiatives announced in Budget 2022.

This report references Te Pae Tata, specifically the work underway to implement actions outlined in that report, acknowledging that Te Pae Tata is the health plan for two years from 2022-2024.

Performance against measures is assessed using a traffic light system, as shown in the key below. The report also includes some demand-driven measures. These do not have a target and are indicated as N/A (not applicable) where shown. In some cases, the process of collation and validation of health system data means that the most up to date information available is for a different timeframe than the quarter one reporting period. Most often, it is taken from the end of the previous quarter (i.e., 1 April – 30 June 2022), although in some situations data is only reported annually, so the report reflects data ending 30 June 2021. The report annotates each table where the data falls outside the quarter one period and makes clear which period it covers.

As our first quarterly report, this report provides a baseline of our future performance in the coming quarters, although where possible the report also includes trend data from the period before the establishment of Te Whatu Ora.

To complement the main body of the report, Appendices are included that provide additional commentary of key issues in each of the four health regions.

In some cases, further work is needed to integrate and consolidate data from different legacy systems.[i] We have provided more detail about this in the next section, including the integration of more meaningful targets. Future quarterly reports will include updates on those targets as well as indicative trends. This will build a clear picture of the impact of our new organisation, Te Whatu Ora, on the health of New Zealanders.

Key		
Criteria description	**Rating**	**Rating Assessment**
Achieved	At or above target	🟢
Not achieved, but progress made	≤ 10% of target	🟡
Not achieved	≥ 10% of target	🔴

Context: Resetting the health system

Delivering Te Pae Tata

Te Pae Tata sets out what Te Whatu Ora will do differently over the next two years to build the foundations a unified, smarter, sustainable and equity-led health system.

The process of transforming the hauora system is a significant undertaking, and one which will take time to complete.

This quarterly report provides a snapshot of performance over the first three months.

The establishment of Te Whatu Ora on 1 July 2022 alongside Te Aka Whai Ora | the Māori Health Authority, provides a platform to address current health inequities, and improve health outcomes for all New Zealanders, but particularly Māori, Pacific people and tangata whaikaha | disabled people.

The table below outlines the three key workstreams that collectively capture our approach to change.

1. Our people are our future	2. Organising ourselves for change	3. Transformative priorities
The purpose of this workstream is to engage and support our people to participate, engage and lead change for themselves and their teams, and work with our people on how we shift culture to align with the future we want. The actions include completion of the Charter, building and supporting clinical and broader leadership development in change, focused actions on wellbeing and enabling regular feedback from teams on change.	This workstream will establish national teams and functions to achieve service shifts, establish regional integration through collaborative team working, establish local delivery through local hospital leadership teams, establish localities, Iwi Māori Partnership Boards and support provider networks to enable care. Consultation with staff on proposed changes is part of this workstream.	This workstream will establish a focused work programme of strategic, operational and tactical priorities that will accelerate our changes as a whole of care system. The priority actions in this workstream are yet to be determined.

Focus for Quarter 2

Following the publication of Te Pae Tata, the work to deliver system change will accelerate in Quarter Two. Actions to deliver Te Pae Tata will be reported and included. These actions cover five areas:

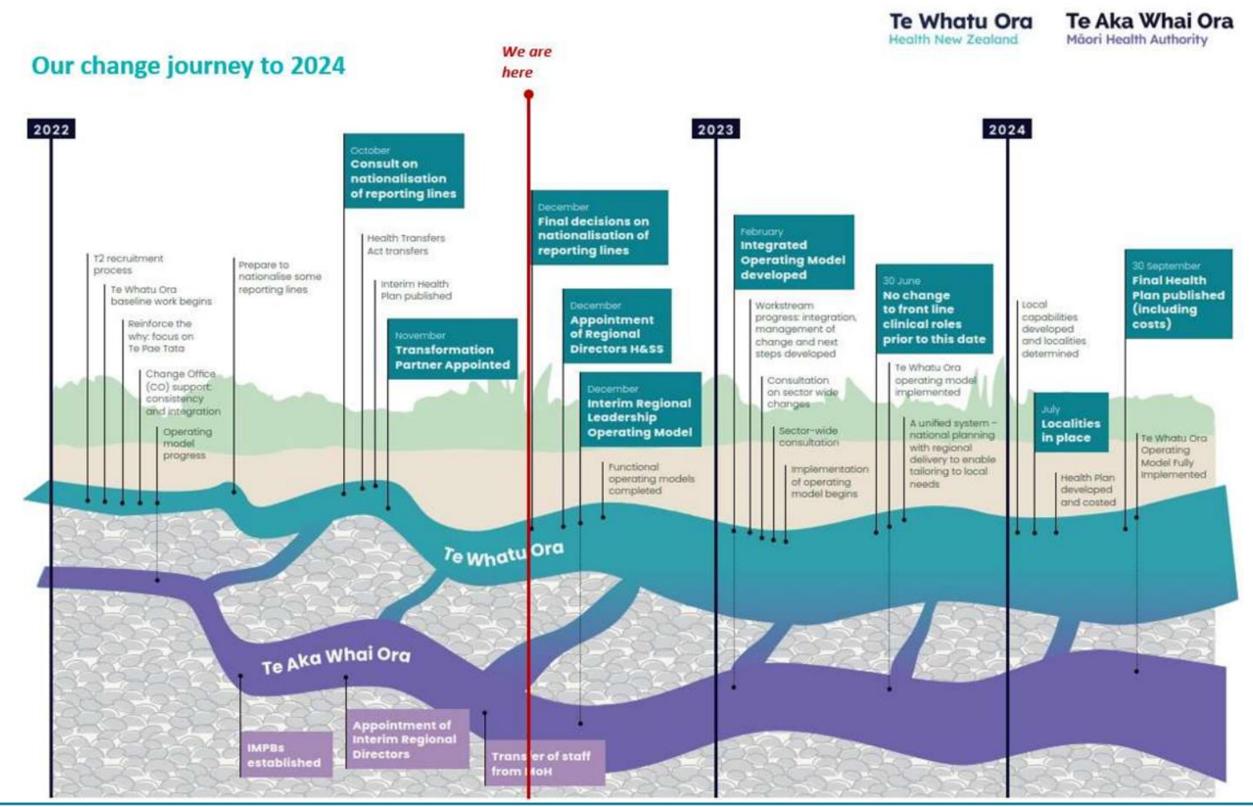
- People and whānau.
- Improving health outcomes.
- A unified health system.
- Priority populations, especially Māori, Pacific peoples and tangata whaikaha | disabled people.
- A focus on performance.

Reporting progress on Te Pae Tata actions will provide transparency and build confidence that Te Whatu Ora is enabling the change needed to deliver on Government expectations.

In addition to quarterly reporting, the Te Whatu Ora Board has approved the publication of an initial health dataset across 12 measures to provide regular transparent monthly reporting of key performance metrics.

Focus for Quarter 3

In Quarter 3 we will report on the outcome of the first step in organising ourselves for change which aims to unify and simplify through consistency, standardisation, and coordination where this makes sense. This step is about bringing us all together into coherent teams were working together nationally and across regions is the norm, not the exception.



We are managing a system of immense scale and complexity

The establishment of Te Whatu Ora represents the largest and most ambitious change to the health system in our history; key facts outlined below attest to that. Transfer of a wide range of pay, financial management and operating services and systems on day one into a single organisation without disruption to healthcare services is a key achievement.

- **7** Shared Service Agencies and their subsidiaries have been integrated into Te Whatu Ora, along with several functions that previously sat in Manatū Hauora
- **$20 billion** Annual operating budget
- **0** Requirement for 'inter-district flows' makes it easier for patients to access the care they need, wherever they are

- **$24 billion** Worth of assets under management
- **82,000** Staff equivalents, including 27,000 nurses and 800 midwives
- **20** District Health Boards integrated into a single, national entity for the first time

We started during the COVID-19 pandemic

This is the first quarterly report for Te Whatu Ora, and it follows an era of unprecedented impact on health services due to the COVID-19 pandemic. The pandemic's impact on the Aotearoa's hauora system can be better understood by looking at the impact on similar health systems overseas. This offers a more objective, transparent assessment and avoids 'assessment bias'.

For the purposes of this report, Te Whatu Ora has drawn on the findings of the report published by the Health Quality Safety Commission **Executive summary: A window on quality 2022 (Part 2) | Whakarāpopototanga matua: He tirohanga kounga 2021 (Wāhanga 2) | Health Quality & Safety Commission (hqsc.govt.nz)**

As well as recognising the "tireless efforts of Aotearoa New Zealand's health care workers during rapid, large-scale change and intense and unprecedented pressure", the report also notes the following outcomes, which form the starting point for the first quarter's performance review:

"Aotearoa New Zealand's experience of and response to the pandemic was different to, and more successful than, most other countries."

"Over the entire period of the pandemic, in total, as of mid-2022, about the same number of people have died as would have been expected in this period, but at different times' [noting more recent data is required to complete this analysis]."

"The Health Quality & Safety Commission's patient experience data shows no significant changes in patient experience since the beginning of the pandemic, e.g., health care workers have delivered a patient experience that compares favourably with that before the pandemic."

Specific observations in the report are:

- The pandemic has contributed to reductions in the rate of childhood immunisations and in the rates of screening for breast and cervical cancer.
- Emergency departments have become increasingly challenged to deliver timely care due to staff being impacted by COVID-19 and greater levels of complexity and demand arising from the pandemic.

- Planned care activity has been reduced due to higher occupancy of acutely unwell patients and unwell staff.
- Cancer services have largely been maintained and cancer registrations have improved since June 2020.
- The pandemic had a profound impact on people's mental health, however, quantifying the extent of this is challenging.
- The health workforce experienced increased levels of burnout and fatigue and mental health issues – as has been experienced in other systems.
- Patient experiences of primary care have neither worsened or improved disparities in access between tangata whaikaha | disabled people and non-disabled people; tangata whaikaha | disabled people continue to experience longstanding disparity.
- The level of complaints to the Health and Disability commissioner increased.

Our starting position – clinical quality

While each local area is continuing to examine clinical quality and progress clinical improvement initiatives, this information is not aggregated in a way to easily summarise the current position at a national level.

Te Whatu Ora is working in partnership with agencies, such as the Health Quality and Safety Commission and the Health Roundtable, to use all available information and intelligence, to advance a national view of clinical quality and agree the priorities for improvement in 2023/2024.

The Health Roundtable is a globally recognised member organisation dedicated to improving healthcare through data insight, knowledge sharing and collaboration. Within this organisation there is the 'NZ Chapter'. It comprises the previous District Health Boards.

Developing our national performance approach

Developing Te Whatu Ora’s performance reporting approach involves consolidating information from 20 former District Health Boards, and seven former shared service agencies, and related subsidiaries, into the first ever view across the Aotearoa New Zealand health system. Initial performance reporting is constrained by what, how and when information is currently collected, with current measures being a mix of on time, real time, near time, and lag time measures. There are also challenges with the mix of systems

for recording performance information, many of which involve manual processes, and in determining an appropriate baseline against which to track performance, due to the impact of COVID-19 and a lack of consistent whole of system performance reporting in the past. As such, building Te Whatu Ora's performance reporting system is a multi-year work programme involving:

- Developing a baseline for performance measures. Due to the challenges outlined above, the first quarterly report will form a baseline for future reports.
- Building processes for drawing together performance data not currently consolidated (including patient and whānau voice).
- Reviewing existing measures for appropriateness going forward.
- Developing new measures e.g., developing equity and unwarranted variation measures, which are highlighted as priorities in Te Pae Tata.

Data quality

Preparation of the first quarterly report has been impacted by data and system constraints including:

- The absence of national reporting systems, data quality and consistency checks.
- Challenges in providing comparatives, with data not comparable with previous collections.
- Variation in pay cycles across Te Whatu Ora, and challenges in aligning these with the reporting in Quarter 1.
- Gaps in some data sets.

Quarter 1 progress

A rapid data automation project is currently underway along with work to connect performance and analytic capability across the organisation. The Board has endorsed a set of metrics for monthly reporting on Te Whatu Ora's website which will commence in Quarter 2.

Priorities for Quarter 2

- **Launch monthly website reporting.**
- **Connect performance and analytic capability across the organisation through the unify to simplify change process.**
- **Continue to build trend analysis for key indicators.**

Equity and embedding Te Tiriti o Waitangi

Equity is at the heart of hauora system transformation

It is well recognised, and many of the population health metrics in this report underscore, that Māori have disproportionately poorer health outcomes compared with other ethnic population groups. To address inequity of outcomes, a major focus of health system reform is to honour the three articles of Te Tiriti o Waitangi through the recommendations of the 2019 Waitangi Tribunal Hauora Report. The Pae Ora Act states that "all health entities [are] to be guided by the health sector principles, which, among other things, are aimed at improving the health sector for Māori and improving hauora Māori outcomes".

This represents a major shift towards an equitable health sector, which includes ensuring Māori and other ethnic population groups:

i. have access to services in proportion to their health needs; and

ii. receive equitable levels of service; and

iii. achieve equitable health outcomes.

A key aspect of better serving Māori populations is changing the way services are delivered in our communities. In the Quarter 1 reporting period, Te Whatu Ora has established the first 12 localities (see page 17). At a system level, Te Whatu Ora has been established alongside Te Aka Whai Ora. A regular pattern of joint meetings by our Boards and Leadership Teams is already a core part of how we do business. We have also developed a shared view of what work will be taken forward together in partnership, and which aspects will be for Te Whatu Ora to deliver, with Te Aka Whai Ora monitoring their impact for tangata whenua.

Priorities for Quarter 2

- **Continued rollout and development of localities work.**
- **We will continue to develop our performance reporting on Te Tiriti o Waitangi in future quarters, including further development of the respective roles of Te Whatu Ora leaders in delivering our obligations in honouring Te Tiriti o Waitangi, and the role of Te Aka Whai Ora as an independent monitor of hauora system performance.**
- **An equitable health system must also better serve communities whose health outcomes are worse than the general population. For this reason, future quarterly reports will also cover our performance in relation to Ola Manuia, a companion document to Te Pae Tata, focused on healthcare for Pacific communities, and feedback from Fatu Fono – the Pacific Health Senate.**

Giving effect to Te Tiriti through localities

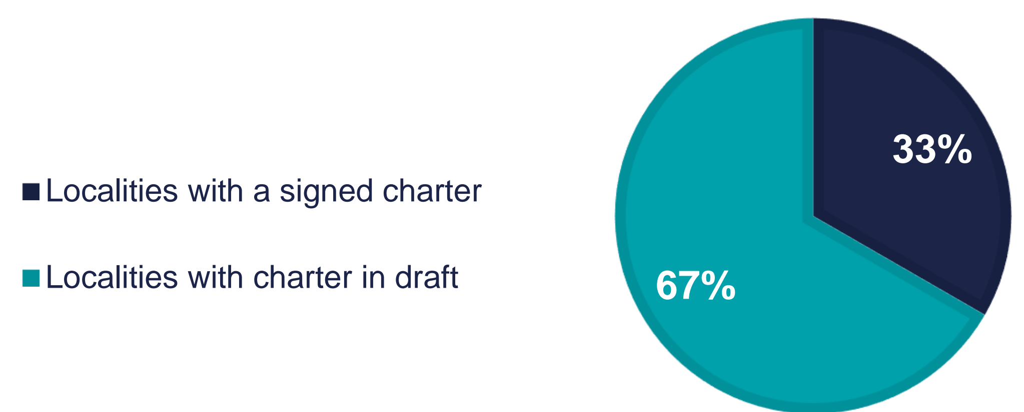
An important objective of the locality approach is to *improve outcomes* for Māori by embedding approaches that uphold Te Tiriti o Waitangi principles in the new health system.

In the development of the first localities, a key *requirement* was the inclusion and involvement of mana whenua, hapū and iwi *leadership* (in the absence of Iwi Māori Partnership Boards).

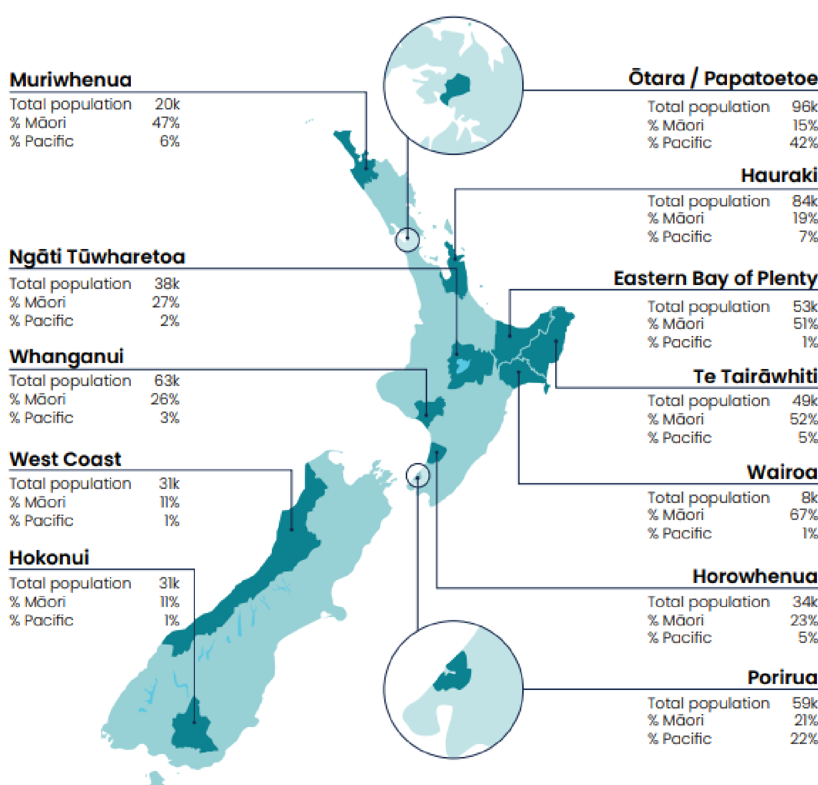
The first locality areas were selected as they met at least one of the following criteria: high *Māori* population, high *Pacific* population, *rural*, and *quintile five* (high need).

Going forward, *Iwi Māori Partnership Boards* will ensure that the *voices* of whānau and mātauranga Māori are represented in the health system by bringing these voices into *service planning* for their rohe.

30+ iwi involved in locality leadership for the first twelve localities



$3.8M invested this quarter to support locality establishment



*Boundaries are subject to agreement with Iwi and local stakeholders

Priorities for embedding Te Tiriti o Waitangi

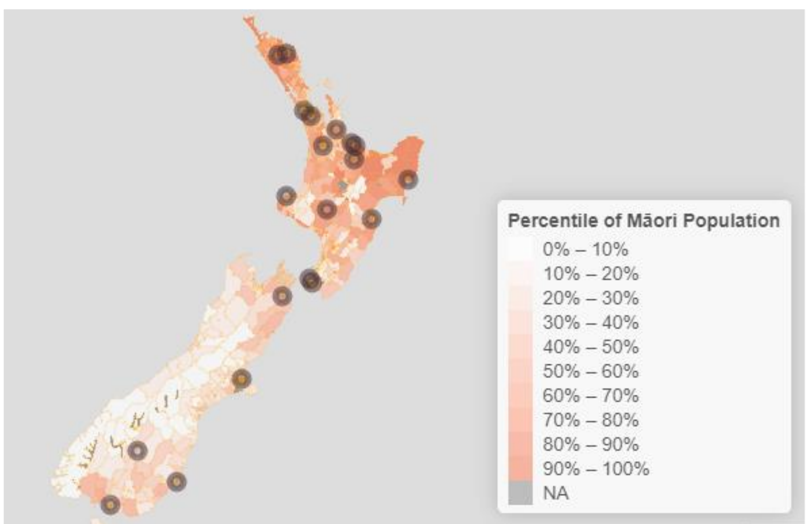
Measures for priority areas as set out in the interim Government Policy Statement for Health, provide accountability for how the hauora system is honouring the articles of te Tiriti o Waitangi. For a more complete understanding of hauora system performance for Māori in the context of equity of outcomes, it should be read in conjunction with the detailed breakdown by ethnicity for health metrics elsewhere in this report, and the Whakamaua dashboard which can be found here: **Whakamaua Dashboard**.

Data on these measures is only available with a substantial time lag. Health funding for Māori providers is currently available annually, and patient experience data for Quarter 3, ending 31 March 2022. Coverage and utilisation of rongoā Māori is annual data from 2020/21. A focus for Te Whatu Ora in Quarter 2 is to work with Te Aka Whai Ora and others across the hauora sector to develop a timely action plan for delivering on these measures.

Target Focus	Progress Measure	Focus Group	Latest Actual
Health entity spending on identified Māori health service providers[1]	Funding for Māori providers	Total	$565.2 million
Experience of health services for Māori as measured by the primary health patient care and adult inpatient surveys[2]	% of Māori in hospital kept informed as much as they wanted to be about their treatment and care	Māori	86%
	% of Māori in hospital treated with kindness and understanding by their doctors.	Māori	93%
	% of Māori in hospital with their cultural needs met	Māori	87%
Geographical coverage and utilisation of rongoā Māori Services[3]	Number of client contacts of rongoā Māori Services	Māori (0-14)	882
		Māori (15-29)	1,050
		Māori (30-44)	1,674
		Māori (45-59)	1,985
		Māori (60+)	4,092

[1] Annual data only. Latest data is for year ending 30 June 2021.
[2] Latest quarterly data available is for Quarter 3 2021-22, ending 31 March 2022.
[3] Annual data only. Latest data is for year ending 30 June 2021.

Geographical coverage and utilisation of rongoā Māori Services*



Keeping people well in their communities

A key contributor to better health outcomes is ensuring people's health needs are met where they are, rather than where the system is. This section focuses on the performance of the health system in keeping people well and out of hospital.

Key points

- Overall, 80% of patients nationally reported getting primary care when they need it. That figure is lower for Māori and tangata whaikaha | disabled people (73% and 74% respectively), which further reinforces health inequities. Māori new-born infants are especially unlikely to be enrolled with a General Practitioner or Kaupapa Māori provider.
- There has been a sharp drop in childhood immunisation levels across Aotearoa New Zealand, when compared with pre-COVID-19 levels, at all age levels measured in this report. The fall is especially pronounced for Māori, further increasing the risk of poor health outcomes.
- There was an increase in overall immunisation rates against influenza for over 65s.
- Data on ambulatory sensitive hospitalisation rates – hospitalisations for conditions that could have been treated in the community are particularly high for Māori and Pacific populations. A programme of work is underway to ensure more people are treated in their communities, which is better for their wellbeing and reduces pressure on the hospital system.

Quarter 2 priorities

- **Delivering the recent announcement to increase funding and enhance the pipeline of qualified doctors entering general practice. This includes funding for Community Based Attachments to incentivise more placements in a broad range of general practices including rural. The implementation of this work is due to be completed in January 2023.**
- **We will work with Te Aka Whai Ora and Manatū Hauora to improve diversity and improve representation for GP training.**
- **Whilst we will aim to provide additional information on public health and primary care this will be challenging in the short-term, owing to the combination of legacy systems, targets and data collection arrangements.**
- **Improving immunisation rates for tamariki Māori is a priority focus for Quarter 2 with national leadership and local initiatives to boost uptake and close the gap that developed due to COVID-19. Developing a Pacific whānau-focused integrated care model for diabetes and implement a dedicated prevention and management programme in South Auckland for Pacific communities.**

Proportion of people with unmet need for primary healthcare

What these measures mean

These measures show which population groups face unmet needs in primary care. The first two indicators reflect the national primary care patient experience survey and have been reported for some time as a Health System Indicator (HSI). One measures access to primary care when patients need it, and the other on whether people feel involved as much as they want in decisions on their treatment. The third indicator provides a measure of timely access and enrolment in General Practice of new-born babies. Early new-born enrolment with General Practice supports on-time immunisations and detection of any early health or social issues emerging. The fourth indicator measures the percentage of the population that are enrolled with primary care (General Practice and Kaupapa Māori providers) with a target of 90% enrolment.

Commentary

80% of primary care patients reported receiving primary care when they needed it in the last 12 months. Māori and tangata whaikaha | disabled people reported lower rates (73% and 74% respectively). The main barrier was the waiting time being too long (13.3% of respondents overall, 17% for Māori).

Other factors included:

- Pressure on the health system stay home orders/ alert level restrictions (4.4%).
- Difficulty taking time off work (1.8%, but 3.5% for Pacific respondents).
- Cost or because they owed money to the general practice/ medical centre (1.6% overall, but 3.1% for Māori).

The most recent primary care patient experience survey results indicated 37.2% of respondents could get same day or next day booking for their most recent appointment, 43.8% within a week and 19% over a week.

Enrolment

68% of Māori new-borns were enrolled with a general practice or a kaupapa Māori provider by 3 months of age. This is significantly lower than the non-Māori, non-Pacific rate of 97% and lower than the 85% target. This represents 1,314 Māori babies not enrolled by 3 months of age compared to 285 non-Māori, non-Pacific babies across Aotearoa New Zealand. One of the drivers of this is lower access to and enrolment in primary care for Māori generally. Closed books in general practice and higher numbers of whānau in transitional housing also contribute to this inequity in access to primary care for Māori babies.

94% of the Aotearoa New Zealand population is enrolled with a primary care provider, compared with 85% of Māori. An estimated 156,794 Māori nationally are not enrolled with a primary care provider. Pacific enrolment rates are 97% and non-Māori, non-Pacific are 96%. Local areas with lower than 80% enrolment rates for Māori include Mid Central (78%), Taranaki (78%), Waitematā (79%) and Counties Manukau (79%).

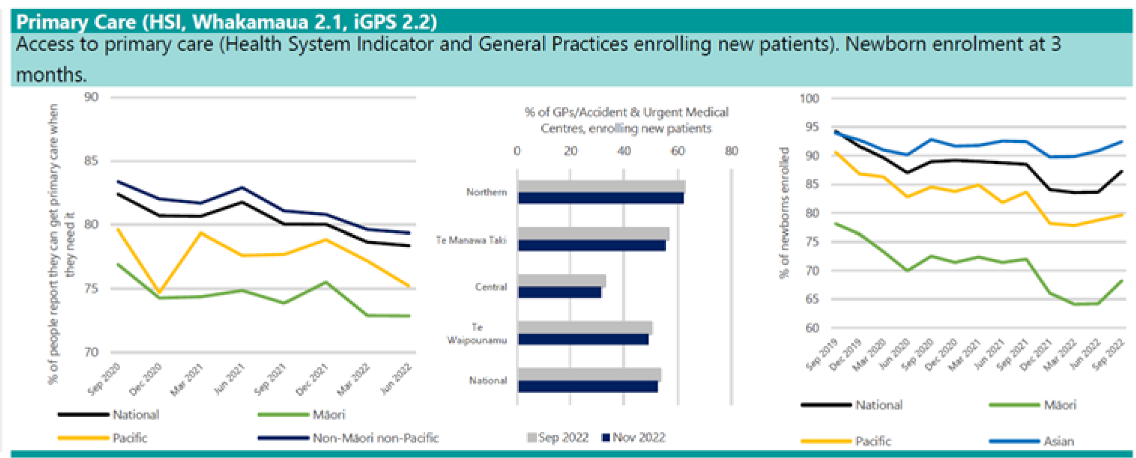
Priorities for Quarter 2

- **Continue the implementation of a revised general practice funding model that is responsive to health need and equitable outcomes for Māori and Pacific.**
- **Commission comprehensive primary and community care models in high Māori populations that address the needs of the community – implement prototype designs with engagement. Extend the Well Child Tamariki Ora Enhanced Support Pilots as part of integrated care models – engagement with partner organisations.**

Target focus	Progress Measure	Target (by region, broken down by ethnicity and treatment type)	Latest Actual	Rating
Unmet need for primary healthcare	% of people who report they can get primary care when they need it [4]	Māori	73%	N/A – target in development
		Pacific	77%	
		Non-Māori, non-Pacific	80%	
		Tangata whaikaha | disabled people	74%	
	% of people who report they were involved as much as they wanted to be in making decisions about their treatment in general practice care [5]	Māori	84%	
		Pacific	84%	
		Non-Māori , non-Pacific	86%	
		Tangata whaikaha | disabled people	84%	
	85% of children enrolled with a general practice or a kaupapa Māori provider by age 3-months[6]	Māori	68%	
		Pacific	80%	
		Tangata whaikaha | disabled people	97%	
	90% of people enrolled with a general practice or a kaupapa Māori provider[7]	Māori	83%	
		Pacific	97%	
		Tangata whaikaha | disabled people	96%	

[4] Latest survey data covers the year Q4 2021 to Q3 2022, ending 31 March 2022.
[5] Latest survey data covers the year Q4 2021 to Q3 2022, ending 31 March 2022.
[6] Data covers period 1 July 2022 to 30 September 2022.
[7] Data covers period 1 July 2022 to 30 September 2022.

The table below shows trend data for reported unmet need, % GPs enrolling new patients and newborn enrolment at 3 months.



Data provided by Manatū Hauora.

Uptake of immunisations

What these measures mean

These measures show key immunisation metrics for at-risk population groups (tamariki, Māori, Pacific people, and over 65s), including the percentage of children who have turned 8 months / 24 months / and 5 years old during the reporting period, who have had all of their age-appropriate vaccinations according to the National Immunisation Schedule. This includes the critical first immunisations at 6 weeks of age as well as immunisations delivered at ages 3 months and 5 months. The influenza vaccination coverage data provided here are for over 65s.

Commentary on childhood immunisations

Immunisation is a critical public health intervention to protect tamariki from a range of preventable diseases that can cause serious illness and death. Childhood immunisation coverage in Aotearoa has fluctuated since 2017 and began trending downwards in 2020 as COVID-19 affected the country. Coverage shows that an equity gap persists and there is lower coverage for tamariki Māori at all milestone ages compared to the total coverage. Immunisation coverage is measured at the key milestone ages of 8 months, 24 months and 5 years.

The COVID-19 pandemic has exacerbated existing pressures on our health and disability system, with increasing equity gaps and declining childhood immunisation rates. The COVID-19 response led to an inevitable reprioritisation of resources and emphasis away from other immunisation programmes, despite actions put in place to increase overall system capacity including the vaccinator workforce.

The Immunisation Taskforce (the Taskforce) has been set up in response to falling rates of childhood immunisation over the last five years. The Taskforce has identified seven priority areas to address barriers to childhood immunisation and increase uptake. These align with actions already underway including:

- Strengthening vaccinator workforce
- Classification of vaccines
- Funding pathways for Māori and Pacific providers
- Solutions for current gaps in the ante-to-post-natal pathway between providers
- Prioritisation of immunisation outreach to achieve on time vaccination in risk-groups
- Immunisation collaterals for consumers
- Immunisation governance

To accelerate the delivery of these actions, Te Whatu Ora is working in partnership with primary care and Māori and Pacific providers, Te Aka Whai Ora and others in the broader health sector, and leveraging the knowledge and resources developed through the delivery of the COVID-19 vaccination programme.

Commentary on HPV immunisation

HPV immunisation protects rangatahi from HPV infection and reduces the risk of developing cervical cancer and a range of other HPV-related diseases. HPV immunisation is funded for everyone aged 9 to 26 (inclusive,) including boys and young men. The vaccine is offered to boys and girls through participating schools at Year 8, around age 12. HPV immunisation is also available free through general practices from 9 years of age.

The HPV immunisation programme is primarily delivered through a schools-based programme and coverage data is reported annually. In 2021/22 (1 July 2021 – 30 June 2022), 54% of rangatahi (2008 birth cohort) were fully immunised against HPV.

The reduced number of in-person school days due to lockdowns and low rates of school attendance in many areas have affected the delivery of HPV immunisation.

The programme is currently working with teams in Te Aka Whai Ora, providers, and key community stakeholders to review the workforce, system enablers, and delivery models for the HPV Immunisation programme.

Uptake on immunisations: Age 8 months, 24 months and 5 years

What these measures mean

These measures show the % of children who have turned 8 months, 24 months and 5 years during the reporting period, who have had all of their age-appropriate vaccinations according to the National Immunisation Schedule. The immunisation measure at 24 months has been reported for some time as a Health System Indicator (HSI).

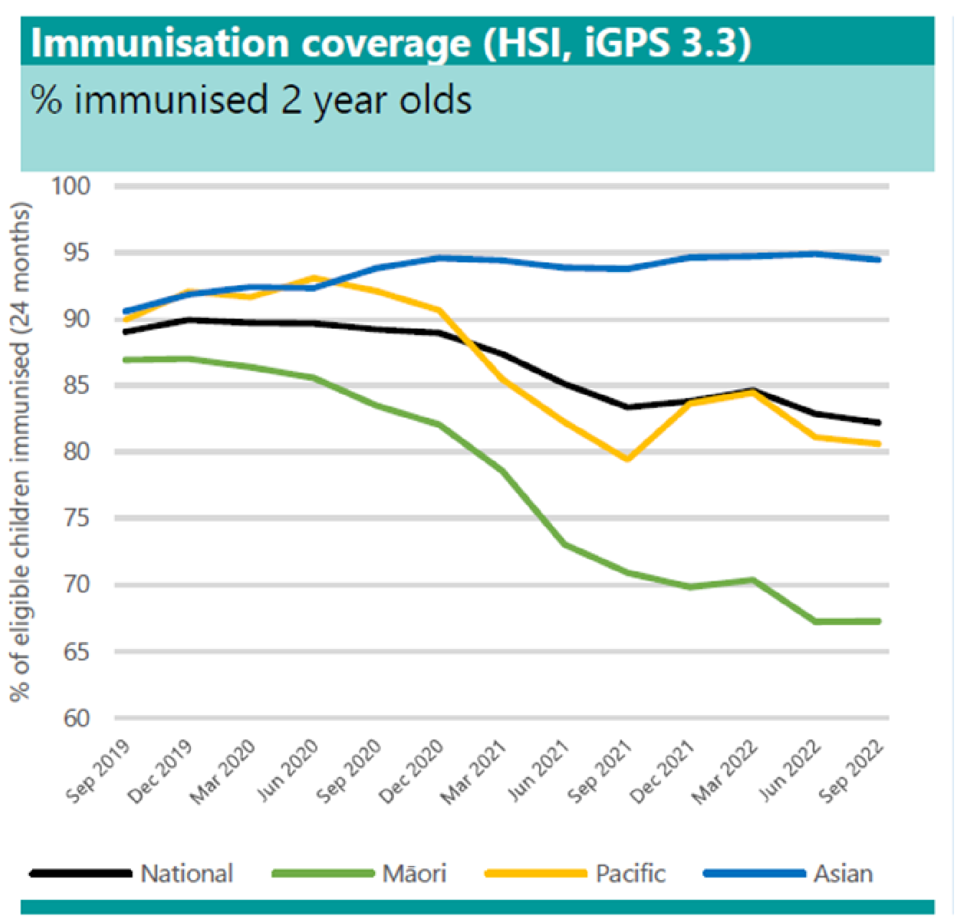
Commentary

There has been a significant reduction in childhood immunisation rates since the COVID-19 pandemic, with the gap especially wide for tamariki Māori. For this latest quarter, national coverage at the 8-month milestone age has remained the same as the previous quarter at 83.7 %. Coverage varies considerably by region (75.5% for Te Manawa Taki to 89.8% for Te Waipounamu) and ethnicity (68.5% for Māori). We are working with Te Aka Whai Ora through the Kahu Taurima programme to maximise opportunities in the first six weeks to improve immunisation rates (e.g., through working with midwifes as well as Tamariki Ora providers). This work is critical in addressing current gaps in the ante-natal to post-natal pathway between providers.

Target focus	Progress Measure	Target (by region, broken down by ethnicity and treatment type)		Actual – Q1 8 months	Q1 rating	Actual – Q1 24 months	Q1 rating	Actual – Q1 5 years	Q1 rating
Immunisation rates	95% of eligible children fully immunised at eight months / 24 months / 5 years[8]	Northern	Māori	67.0%	●	63.1%	●	68.4%	●
			Pacific	83.3%	●	70.4%	●	75.6%	●
			Non-Māori, non-Pacific	90.2%	●	88.3%	●	83.3%	●
		Te Manawa Taki	Māori	61.4%	●	63.0%	●	64.0%	●
			Pacific	73.1%	●	71.7%	●	73.6%	●
			Non-Māori, non-Pacific	84.2%	●	82.9%	●	80.7%	●
		Central	Māori	72.1%	●	70.4%	●	78.6%	●
			Pacific	89.6%	●	85.9%	●	83.6%	●
			Non-Māori, non-Pacific	91.2%	●	89.3%	●	90.0%	●
		Te Waipounamu	Māori	81.3%	●	82.2%	●	84.4%	●
			Pacific	91.9%	●	88.5%	●	89.4%	●
			Non-Māori, non-Pacific	91.9%	●	92.0%	●	91.6%	●

[8] The coverage data shown here is for the reporting period 1 July-30 September 2022, extracted from Qlik app on 10 October 2022.

The table below shows trend data for immunisations at age 2.



Data provided by Manatū Hauora.

*Notes for childhood immunisation coverage data

- Childhood immunisation coverage data is updated quarterly from the National Immunisation Register via Qlik, and is available by local area, deprivation level and ethnicity.
- Regional numbers are an amalgamation of areas which are based on the child's recorded address information.
- The number of eligible children in each category (denominator) is based on current NIR enrolments.
- Numbers are subject to change as late vaccination events are entered into the systems.
- The data presented is by birth cohort e.g., rates are for tamariki who become eligible for vaccinations and then have completed those vaccinations in line with the schedule by 8 months, 24 months and 5 years.

Uptake of immunisations: HPV

What these measures mean

This measure shows the percentage of children who turned 12 years old during the reporting period and are fully immunised against HPV. The HPV Immunisation Programme is primarily delivered through a schools-based programme and coverage data are reported annually.

Commentary

Challenges that have affected the delivery of HPV immunisation over the last two years include the reduced number of in-person school days due to COVID-19 Alert Level restrictions, overall low rates of school attendance in some regions, and the significant impact of COVID-19 on staff and whānau. There are other barriers to vaccination that are not in the health system, for example vaccine fatigue and hesitancy, disinformation or parental concerns about HPV vaccination.

We are establishing a school-based Immunisation Working Group to provide operational and strategic input. The Programme is working across local areas to understand how HPV immunisation is delivered in their area and encouraging school-based vaccinations in any immunisation planning or initiatives for 2022/23, particularly for Māori and Pacific rangatahi.

Target focus	Progress Measure	Target	2020/2021 (2007 birth cohort)	FY rating	2021/2022 (2008 birth cohort)	FY rating
Immunisation rates - HPV	75% of eligible boys and girls fully immunised with HPV vaccine for Māori, Pacific and Total populations	Total	62.5%	● (red)	54.0%	● (red)
		Māori	56.9%	● (red)	48.5%	● (red)
		Pacific	60.8%	● (red)	46.2%	● (red)
		Asian	72.8%	● (yellow)	58.2%	● (red)
		Other	62.8%	● (red)	57.2%	● (red)

Uptake of immunisations: Influenza for 65+ (annual)

What these measures mean

This measure shows the percentage of the population aged 65 years and over who have received at least one annual influenza vaccine during the influenza season, defined as 1 March – 30 September 2022. Coverage for those aged 65 years and over is monitored as this age group has one of the highest rates of hospital admissions for influenza-related severe acute respiratory infections.

Commentary

Over the previous two influenza seasons (2022 and 2021), there has been less circulating influenza in the community due to the COVID-19 pandemic and the closure of Aotearoa's international border. For people aged 65 years and over, there was a 7.6% increase in immunisation rates from 63.4% in 2021 to 71% in 2022, equalling an additional 54,563 people. Coverage for Māori improved significantly by 13.8% to 67.2% this year, equalling an additional 17,199 people. A wide range of initiatives were implemented to support uptake, including:

- Enabling and encouraging utilisation of existing COVID-19 infrastructure to provide a broader range of access options e.g., pharmacies, pop-up events, and additional vaccinators.
- Working with Pharmac on the extension to eligibility to include Māori and Pacific aged 55-64, children aged 3-12, and people with serious mental health or addiction needs.
- Encouraging vaccination of children aged under 2 admitted to hospital.
- Direct marketing campaigns to target populations.
- Temporary top-up payments for vaccine administration to Māori and Pacific peoples.
- Working closely with local areas to support vaccine uptake amongst healthcare workers.
- The development of a digital portal for employers of healthcare workers to claim for influenza vaccination.

This influenza season, the sector was also able to use the COVID-19 immunisation register (CIR) as well as the National immunisation register (NIR), to capture a wider range of influenza vaccines (both funded and unfunded) for the first time, both improving the accuracy of reported coverage and enabling more detailed planning for future years.

Uptake of immunisations – Influenza for 65+
Compared to March - September last year
2022
2021
Māori
67.1%
53.4%
Pacific Peoples
64.8%
66.5%
NMNP
71.5%
64.1%

Target focus	Progress Measure	Target (by region, broken down by ethnicity and treatment type)		Actual	Rating
Immunisation rates	75% of eligible population aged 65 years and over immunised against influenza (annual immunisation)[9]	Northern	Māori	65.4%	🔴
			Pacific	63.7%	🔴
			Non-Māori, non-Pacific	67.5%	🟡
		Te Manawa Taki	Māori	64.9%	🔴
			Pacific	61.0%	🔴
			Non-Māori, non-Pacific	70.2%	🟡
		Central	Māori	69.3%	🟡
			Pacific	69.1%	🟡
			Non-Māori, non-Pacific	74.7%	🟡
		Te Waipounamu	Māori	73.6%	🟡
			Pacific	70.7%	🟡
			Non-Māori, non-Pacific	74.7%	🟡

[9] Coverage data is updated annually from the National Immunisation Register (NIR; and this year also from the COVID-19 Immunisation Register or CIR) reported via Qlik and is available by district and prioritised ethnicity.

Rate of diabetes complications, and selected ASH rates

What these measures mean

These indicators help assess the effectiveness and equity of long term/chronic condition management in primary care. Diabetes is a major long-term condition that disproportionately impacts Māori and Pacific islanders and has significant downstream impacts and costs for whānau and the health and disability system. The indicator measures the rate of all patients with diabetes who have a publicly funded hospitalisations with a diabetes related complication (limb amputation or renal failure only) in the year.

Ambulatory sensitive hospitalisations (ASH) are hospitalisations that could instead have been treated or managed in primary or community care, for example, by GPs, dentists, nurses, or other health professionals. Social and environmental factors such as socioeconomic status and health behaviours can have a big impact on the ASH measure. For people aged 45-64, ASH rates can indicate the effectiveness of primary and community care in screening and managing chronic conditions. The top five ASH conditions in this age group are more likely to be myocardial infarction, angina and chest pain, cellulitis, gastroenteritis and chronic obstructive pulmonary disease (COPD).

Commentary

The rate of complications per 100,000 people with diabetes decreased 7.3% between 2020 and 2021 from 246.9 per 100,000 people with diabetes in 2020 to 228.9 per 100,000 in 2021. In 2021, 731 people with diabetes were hospitalised with a diabetes-related complication. Māori rates of complications (338.1 per 100,000 people with diabetes) are 1.6 times higher those of non- Māori or Pacific. Pacific peoples have similar rates to the wider non-Māori population. Highest rates of diabetes complications by local area are West Coast (607.7 per 100,000 - this may be driven by small numbers), Northland (353.8 per 100,00), Tairawhiti (337.8 per 100,000), Taranaki (327.1 per 100,000) and Wairarapa (318.2 per 100,000).

ASH for cardiovascular conditions in the 45-64 age group for Māori are 1.8 times rates of Non-Māori, non-Pacific, and rates for Pacific people are even higher at 2.2 times. The largest equity gap is in cardiovascular conditions, congestive heart failure (6.9 times higher for Māori compared to non-Māori, non-Pacific rates and 6.2 times for Pacific peoples compared to non- Māori or Pacific) and hypertensive disease (2.3 times higher for Māori compared to non-Māori, non-Pacific and 3.8 times higher for Pacific peoples compared to non-Māori, non-Pacific). ASH hospitalisations for respiratory conditions in the 45-64 years

age group for Māori are 4.1 times the rates of non-Māori, non-Pacific Non-Māori, non-Pacific. Pacific peoples' rates are 3.5 times the rates of non- Māori or Pacific.

The conditions with the largest equity gap between Māori and non-Māori, non-Pacific are COPD (5.7 times higher for Māori) and asthma (4.6 times higher for Māori). The conditions with the largest equity gap between Pacific and non-Māori, non-Pacific are asthma (5.3 times higher for Pacific) and Upper and ENT respiratory (4.1 times for Pacific).

Target focus	Progress Measure	Actual[10]	
Rate of diabetes complications	Rate of people hospitalised for diabetes complications per 100,000	Māori	336
		Pacific	220
		Non-Māori, non-Pacific	206
	ASH admissions rate for cardiovascular conditions (45-64)	Māori	2,534
		Pacific	3,111
		Non-Māori, non-Pacific	1,408
	Ambulatory Sensitive Hospitalisations admissions rate for respiratory conditions (45-64)	Māori	1,439
		Pacific	1,227
		Non-Māori, non-Pacific	349

[10] Latest data covers the period ending Q4 2021, ending 30 June 2021.

Quarter 2 Priorities

- **Implement accessible and nationally consistent clinical pathways for diabetes, cardiovascular diseases, respiratory conditions, stroke and gout, supporting specialist teams to integrate with primary and community care providers to create seamless pathways for whānau.**
- **Commence engagement to standardise national base health pathways across priority long term conditions (stroke, gout, diabetes, CVD). Prototype designs with engagement.**
- **Develop a Pacific whanau focused integrated care model for diabetes and implement a dedicated prevention and management programme in South Auckland for Pacific communities. Scope current models of care/contracts for active pilots. Establish working/steering group to agree commissioning approach and scope of pilot.**

Avoidable hospital admissions: 0-4 years

This measure has been reported for some time as a Health System Indicator (HSI). Te Whatu Ora is developing an integrated programme of work across the Hospital and Specialist Services, Commissioning, and Improvement and Innovation teams to address challenges in acute flow. A core element of this will be focused on avoidable hospital admissions, for example, through potential expansion of initiatives such as Primary Options for Acute Care.

Target focus	Progress Measure	Target (by region, broken down by ethnicity and treatment type)		Actual[11]	Relative rate compared to NZ rate for non-Māori/ non-Pacific
Rate of hospital admissions for an illness that might have been prevented or better managed in the community, reported by key age groups	The rate of hospital admissions for children under five years of age for an illness that might have been prevented or better managed in the community (baseline 2019 annual data)	Northern	Māori	5,695	1.19
			Pacific	9,620	2.01
			Non-Māori, non-Pacific	3,875	0.81
		Te Manawa Taki	Māori	7,333	1.53
			Pacific	8,417	1.75
			Non-Māori, non-Pacific	5,645	1.18
		Central North Island	Māori	6,901	1.44
			Pacific	11,500	2.40
			Non-Māori, non-Pacific	4,976	1.04
		Te Waipounamu	Māori	5,874	1.22
			Pacific	9,655	2.01
			Non-Māori, non-Pacific	4,691	0.98
		Average rate for Aotearoa New Zealand*	Māori	6,451	1.34
			Pacific	9,798	2.04
			Non-Māori, non-Pacific	4,797	1.00

* Average is calculated using a simple division across the four regions. A more accurate calculation based on population data will inform Quarter 2.

[11] Latest ASH data covers the year ending 30 June 2022.

Avoidable hospital admissions: 45-64 years

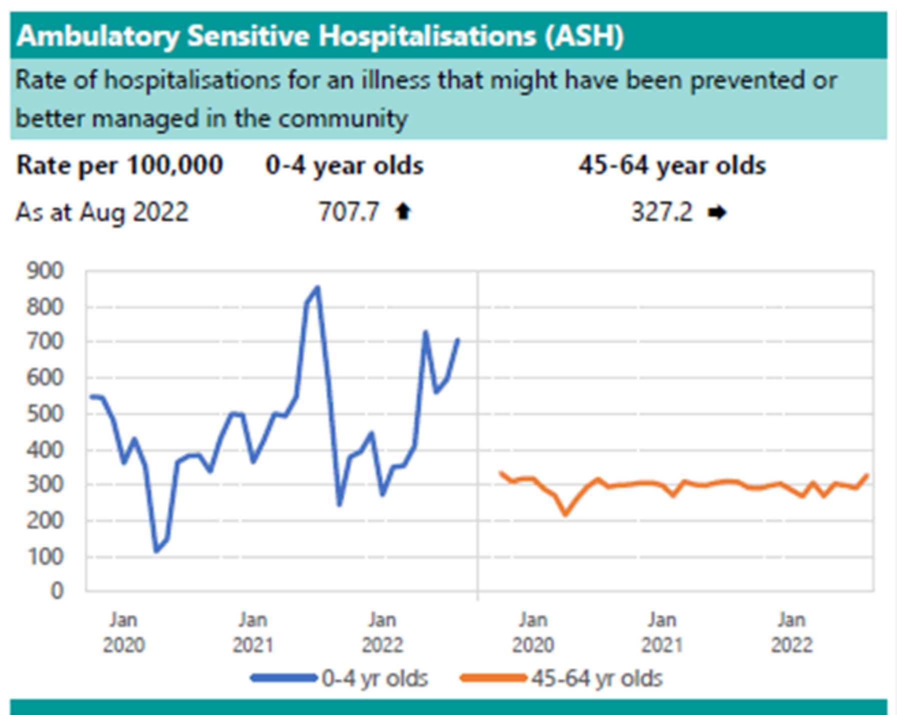
As with the previous commentary on ASH for children aged 0-4, this measure has been reported for some time as a Health System Indicator (HSI).

Target focus	Progress Measure	Target (by region, broken down by ethnicity and treatment type)		Latest Actual[12]	Relativity compared to NZ rate for non-Māori, non-Pacific
Rate of hospital admissions for an illness that might have been prevented or better managed in the community, reported by key age groups	The rate of hospital admissions for people aged 45–64 years for an illness that might have been prevented or better managed in the community (baseline 2019 annual data)	Northern	Māori	6,933	2.3
			Pacific	7,330	2.5
			Non-Māori, non-Pacific	2,880	1.0
		Te Manawa Taki	Māori	7,329	2.5
			Pacific	6,766	2.3
			Non-Māori, non-Pacific	3,284	1.1
		Central North Island	Māori	6,522	2.2
			Pacific	6,468	2.2
			Non-Māori, non-Pacific	3,285	1.1
		Te Waipounamu	Māori	4,082	1.4
			Pacific	3,625	1.2
			Non-Māori, non-Pacific	2,365	0.8
		Average rate for Aotearoa New Zealand*	Māori	6,217	2.1
			Pacific	6,047	2.0
			Non-Māori, non-Pacific	2,954	1.0

[12] Latest ASH data covers the year ending 30 June 2022

* Average is calculated using a simple division across the four regions. A more accurate calculation based on national population data will inform Quarter 2

The table below shows trend data for Ambulatory Sensitive Hospitalisations



Data provided by Manatū Hauora.

Public health: Helping smokers to quit

What these measures mean

These measures show how well primary care is performing in offering support to people who smoke. This includes brief advice, a referral to a local stop smoking service, or a prescription for a smoking cessation medication such as nicotine replacement therapy (eg, nicotine patches and gum). We know that people who get an offer of support to quit from a GP or other health professionals are more likely to quit than those who don't.

Commentary

As the results show, no region is meeting the target of 90%. This likely reflects the current pressures on our primary care workforce. Three of the four regions are under-performing for Māori, compared with non-Māori, non-Pacific. One of the actions of the Smokefree Aotearoa 2025 action plan is to improve the quality of referrals to stop smoking services by

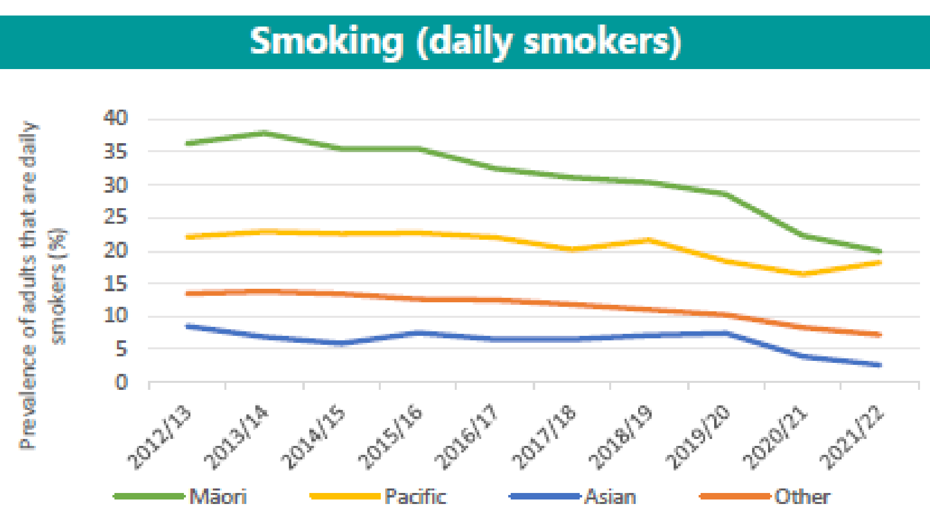
primary and secondary care health practitioners across the health system. This should increase performance against this measure.

Target focus	Progress Measure	Target (by region, by ethnicity)		Actual – Q1[13]	Q1 rating
Provision of other public health services	90% of smokers offered help to quit in past 15-months	Northern	Māori	69%	
			Pacific	80%	
			Non-Māori, non-Pacific	68%	
		Te Manawa Taki	Māori	62%	
			Pacific	60%	
			Non-Māori, non-Pacific	70%	
		Central	Māori	53%	
			Pacific	52%	
			Non-Māori, non-Pacific	54%	
		Te Waipounamu	Māori	72%	
			Pacific	72%	
			Non-Māori,	77%	

[13] Data denotes offer of help to quit smoking for all identified smokers aged 15-74 enrolled with a Primary Health Organisation (PHO) over the 15-month period from 1 July 2021 to 30 September 2022

			non-Pacific		

The table below shows trend data for daily smokers, broken down by ethnicity.



Data provided by Manatū Hauora.

Public health: Raising healthy children

What these measures mean

This measure reflects whether those children identified as obese at the time of the B4 School Check (B4SC) are referred to primary or other care for whānau support.

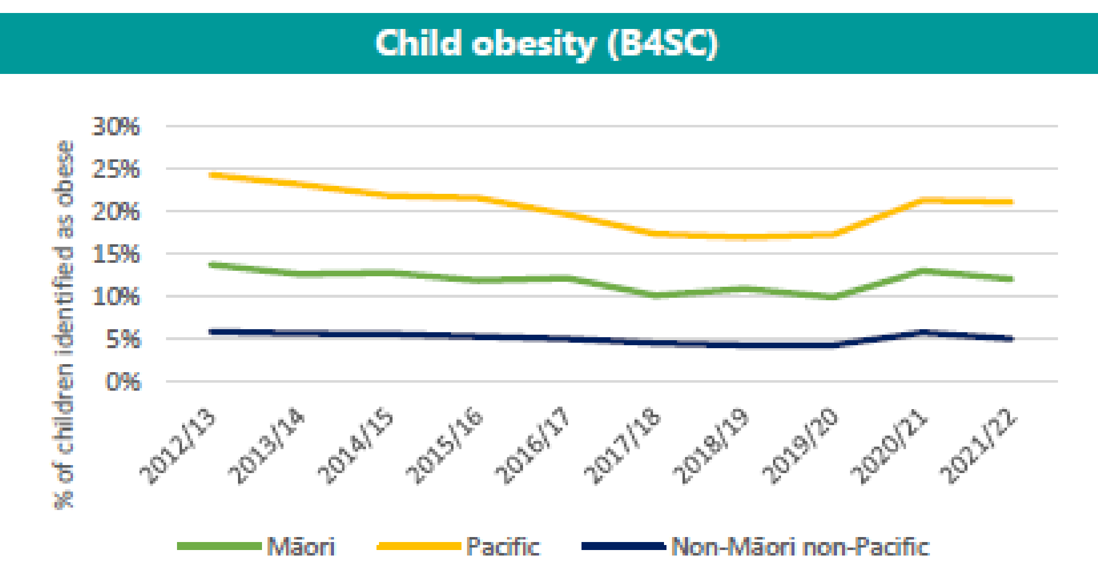
Commentary

The B4SC occurs when a child is 4 years old. The number of children who are found to be obese is relatively small, but it is important that those identified are referred to community supports. Total national obesity referral rates are improving. However, there has been a lower rate of referrals in Quarter 1 2022/23 in the central region which will be addressed in ongoing provider engagement.

Work is underway to source data and develop reporting on an additional public health target, focused on childhood enrolment with an oral health service. We expect to provide an update in the Quarter 2 report.

Target focus	Progress Measure	Target (by region, by ethnicity)		Actual – Q1	Q1 rating
Provision of other public health services	95% of obese children referred to a specialist service have their referral acknowledged	Northern	Māori	99%	🟢
			Pacific	99%	🟢
			Non-Māori, non-Pacific	99%	🟢
		Te Manawa Taki	Māori	89%	🟡
			Pacific	100%	🟢
			Non-Māori, non-Pacific	96%	🟢
		Central	Māori	94%	🟡
			Pacific	86%	🟡
			Non-Māori, non-Pacific	89%	🟡
		Te Waipounamu	Māori	98%	🟢
			Pacific	91%	🟡
			Non-Māori, non-Pacific	97%	🟢

The graph below shows trend data for childhood obesity identified in the Before School Check.



Data provided by Manatū Hauora.

Service performance: Acute demand

Emergency department attendances continue the trend from the last 12 months, with some hospitals experiencing record daily attendance volumes. This is because of sustained demand and a reduction in access to proactive primary care interventions.

The challenges with discharge to alternative settings, as community providers come under increasing pressure due to workforce constraints and demand, along with increasing acuity, has resulted in lengthening stays in hospital and emergency departments. Bed numbers have plateaued since April 2022 when investment was made into a range of ward facilities to support COVID-19 admissions.

The combination of increased demand, and a plateauing bed base, has resulted in longer lengths of stay in emergency departments. This is similar to the experience of other health systems.

Quarter 2 priorities

There are a range of initiatives underway to mitigate these impacts. These include:

- **Additional funding to increase planned care volumes.**
- **Funding to support other initiatives to improve care flow.**
- **An ambitious and wide-ranging programme of improvement and capacity expansion to support improved flow through the acute system to reduce hospital access block and avoid congestion in Emergency Departments.**
- **Developing a dashboard showing hospital system capacity and pressures for inclusion in future quarterly reporting.**

Emergency Department demand and hospital capacity

Commentary

Although the peak of COVID-19 and seasonal illness pressures has passed, Emergency Department (ED) attendances remain high. Acute admissions are currently at the highest point since daily sitrep reporting began, with a reduction in achievement against Shorter Stay in Emergency Department (SSED) targets.[14]

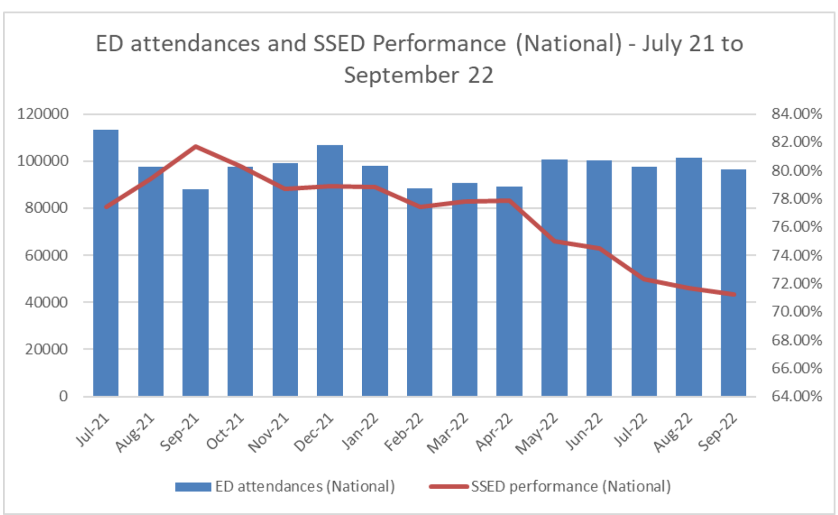
Even with enhanced demand diversion/avoidance initiatives, the admitted cohort will continue to place pressure on hospital capacity.

Acute hospital bed days have been reported for some time as a Health System Indicator (HSI). Bed numbers have plateaued since April 2022. The bed base has not been able to expand sufficiently to absorb increased demand with reduced flow, leading to sustained periods where occupancy is above optimal levels.

To provide perspective on the challenges comparable countries have faced due to COVID-19, the second figure provides data (over a longer timeframe) for ED performance at NHS

[14] As a result of the health system reform, the previous data source for this Emergency Department (ED) measure has been discontinued from 1 July 2022. Data for this ED measure is now sourced from the National Non-Admitted Patient Collection (NNPAC) National Collection, however caution should be used when comparing different published data sources

England. This figure is extracted from the HQSC report on COVID-19 response referred to in the Context Section of this report.



Source: National Non-Admitted Patients Collection (NNPAC) data. New Zealand data.

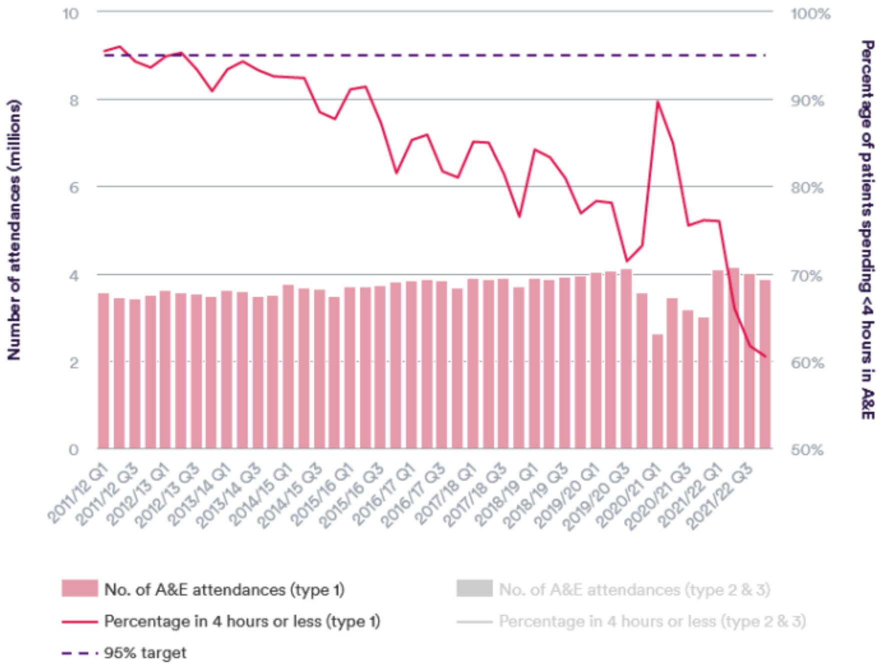


Figure (above): NHS England access to equivalent emergency departments, number of presentations and percent of patients admitted, transferred or discharged within four hours, England, 2011/12–2021/22

Source: HQSC- **https://www.hqsc.govt.nz/assets/Our-data/Publications-resources/COVIDWindow2022Part2-final-web.pdf**

Hospital capacity and duration of stay

Commentary

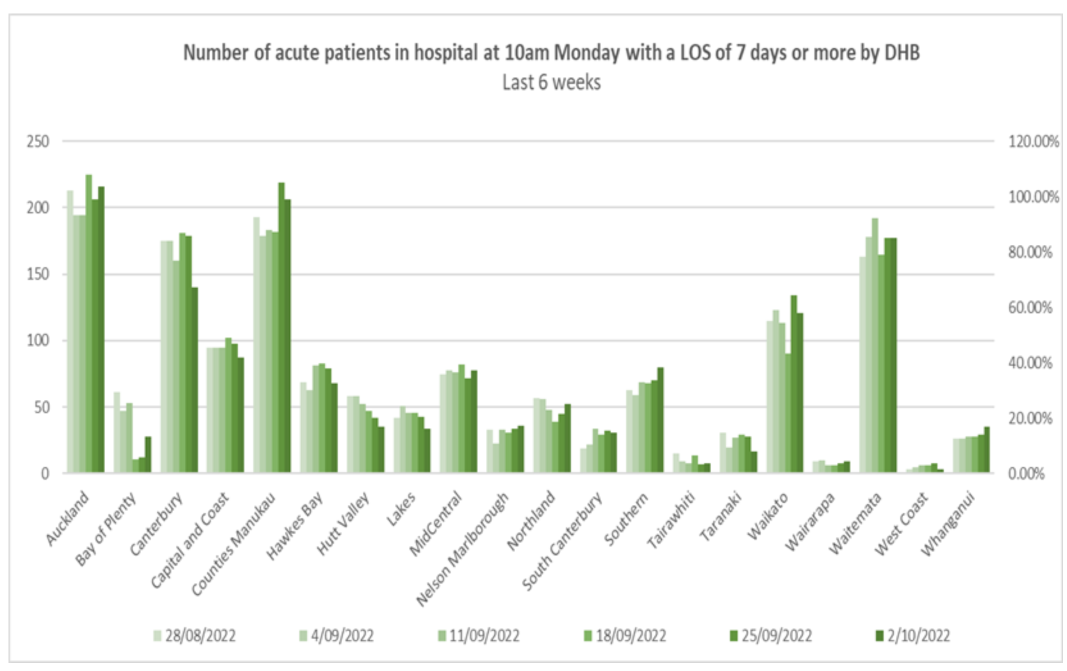
Shorter stays in Emergency Departments (SSED) performance have deteriorated over winter. Emergency Departments are crowded due to a combination of demand and reduced flow leading to increased hospital access block. This has led to increases in ambulance handover delays (mainly in major North Island urban centres) as Emergency Departments are less able to accommodate patients within the facility in a timely manner.

Next steps

All regional and local leaders have been advised of additional funding to increase planned care volumes. Regions have also been advised that this money can be used for initiatives to improve acute flow and reduce length of stay, recognising the interdependency between acute demand and planned care.

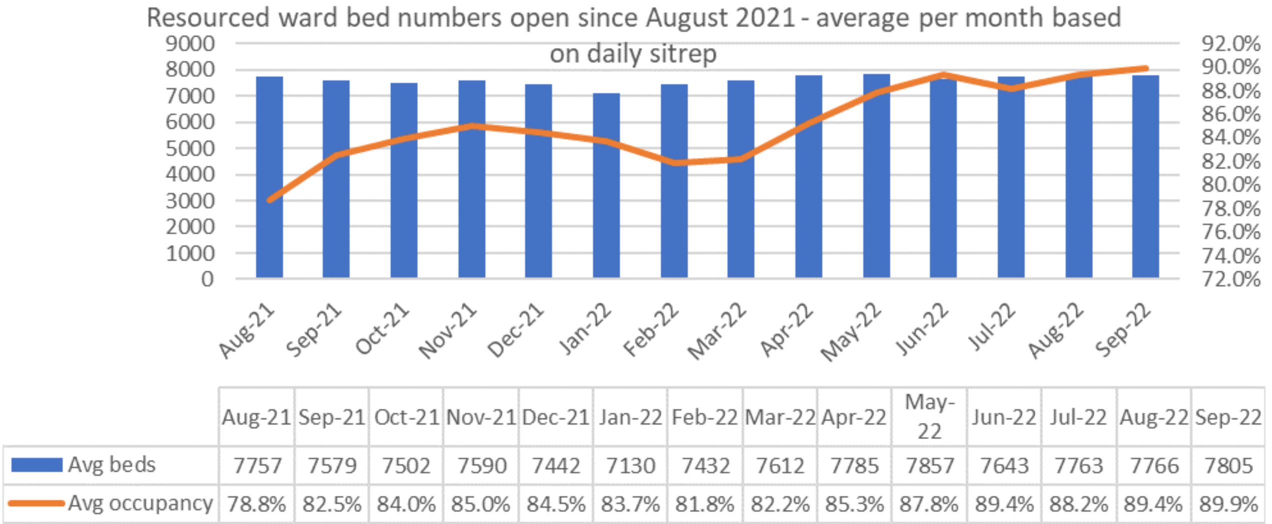
Building on successful initiatives in place in several areas, a National Flow Collaborative is being established to drive improvement in acute flow management and mitigate acute demand pressures. This is an organisation-wide programme across the Hospital and Specialist Services, Innovation and Improvement, and Commissioning teams.

Length of stay in hospital



Source: Te Whatu Ora data

Hospital Capacity



	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Avg beds	7757	7579	7502	7590	7442	7130	7432	7612	7785	7857	7643	7763	7766	7805
Avg occupancy	78.8%	82.5%	84.0%	85.0%	84.5%	83.7%	81.8%	82.2%	85.3%	87.8%	89.4%	88.2%	89.4%	89.9%

Source: Te Whatu Ora data

Service performance: Planned care

Patient access to planned care has been reported for some time as a Health System Indicator (HSI). The number of patients waiting beyond four months for a first specialist assessment (FSA) fell from 37,297 in July 2022 to 34,697 in August and for treatment from 29,187 in July to 28,109 in August as local areas work to address the number of patients waiting beyond expectation despite capacity and work force constraints.

The number of planned care interventions increased in August, although this is in part due to an increased volume of minor procedures, which is counteracting the lower volumes of inpatient planned surgery (due to the capacity constraints outlined). The Hospital and Specialist Services team already have several urgent actions mainly focused on booking of long-wait patients.

Long wait numbers (people waiting longer than 365 days for treatment) fell from 5,143 in July 2022 to 4,832 in August 2022. Long wait numbers for First Specialist Assessments fell from 5,854 in July 2022 to 5,587 in August 2022.

The reset and restore plan launched in October 2022 aims to progressively improve inpatient surgical performance by focusing on system wide actions to address access, capacity and flow. **https://www.tewhatuora.govt.nz/assets/Taskforces/Reset-and-restore-plan-confirmed-final-20220902.pdf**

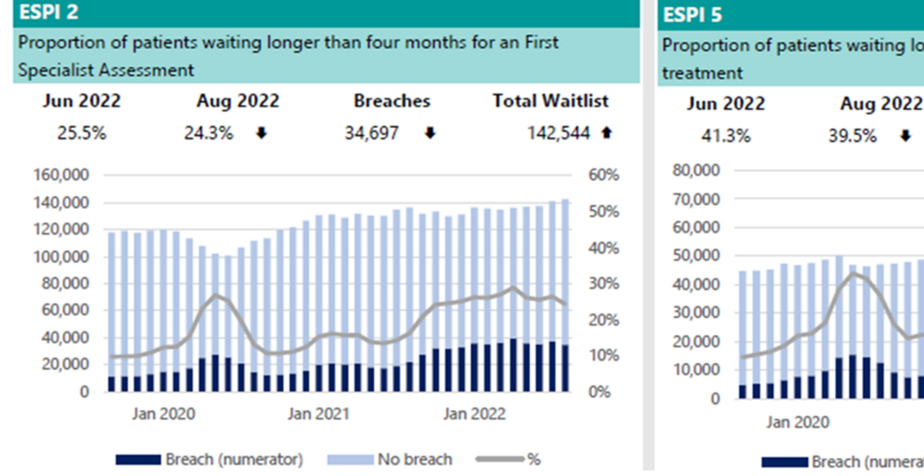
- Disruption to cancer screening services due to the impact of COVID-19 continues to affect achievement of related targets, especially for Māori and Pacific peoples who suffered a disproportionate burden of the pandemic.
- Reported performance against a key metric for 80% of under-25s accessing mental health services within three weeks was above target across all regions.

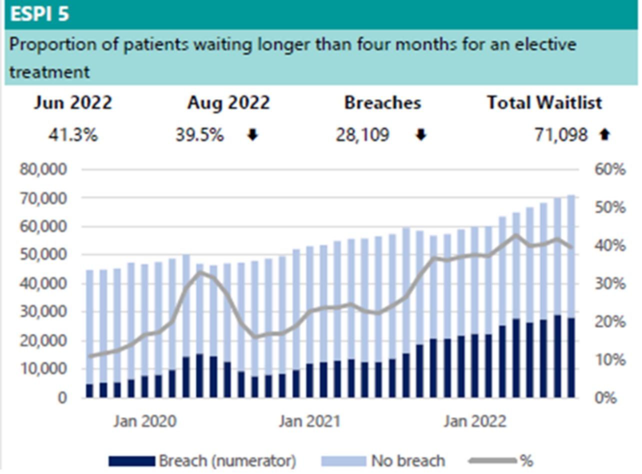
Quarter 2 priorities

- **Improve equitable access to screening through awareness-raising campaigns for Cervical Screening, trialling regional campaigns using tools developed during COVID-19 to spread the message about vaccines, investigating a hub model for the Auckland region breast screening providers to support collaborative approaches to increasing coverage in the region and supporting Māori and Pacific participation in all cancer screening programmes.**
- **Rollout of mental health services through the Access and Choice Program.**
- **Developing reporting on targets related to access to surgeries and other care.**

Planned care: Waiting times

The number of patients waiting greater than four months for a First Specialist Assessment (FSA) reduced from 37,297 in July 2022 to 34,697 in August 2022 (a reduction of 2,600 or 6.9%) and for treatment from 29,187 in July 2022 to 28,109 in August 2022 (1,078 or 3.7%) as local areas work to address the number of patients waiting beyond expectation despite capacity and work force constraints.





Data provided by Manatū Hauora.

Orthopaedic ESPI 2 (FSAs) and ESPI 5 (treatment) have the highest number of patients waiting > 4 months. August 2022 data shows 7,351 (7,654 in July) patients waiting longer than four months for orthopaedic treatment and with 6,689 (7,913 in July) waiting > 4 months for an FSA. Orthopaedic conditions are generally not life threatening and are therefore one of the first specialities to be cancelled when local areas have determined what type of planned care must be postponed to address acute and urgent/semi urgent demand.

Data Note: Planned care data is collected on a monthly basis, two months in arrears. This enables local areas to accurately reflect bookings and delivery, although the datasets are dynamic and consequently the numbers vary dependent on when data is extracted on different days. This is particularly relevant for data collated from recent dates not yet finalised. Te Whatu Ora is in the process of transferring some systems from Manatū Hauora and consolidating and establishing new systems to store and collect information previously only held by District Health Boards. This is an ongoing process within a long-term programme, and in the interim more regular data is limited.

Proportion of people who receive planned specialist care within 4 months

The percent of patients having been given a commitment to treatment and not receiving treatment within four months ranges between 37% and 43% by region. This increases for Māori (44-48%) and Pacific (33-54%).

For Quarter 2, Te Whatu Ora will focus effort on prioritising treatment for those who have been waiting longest along with Māori and Pacific patients – there are 4,832 patients in Aotearoa New Zealand who have been waiting longer than 12 months for a FSA, and 5,587 patients waiting longer than 12 months for treatment.

We are also aiming to publish a more detailed breakdown of waiting time data, including by the top 10 specialties by volume.

Target focus	Progress Measure	Target	Actual[15]			Rating
Rates of access to treatment, following a first specialist assessment	People given a commitment to treatment but not treated within four months	0% of people given a commitment to treatment but not treated within four months	Northern	Māori	44%	🔴
				Pacific	33%	🔴
				Non-Māori, non-Pacific	37%	🔴
				Total	37%	🔴
			Te Manawa Taki	Māori	44%	🔴
				Pacific	40%	🔴
				Non-Māori, non-Pacific	40%	🔴
				Total	41%	🔴
			Central	Māori	46%	🔴
				Pacific	41%	🔴
				Non-Māori, non-Pacific	43%	🔴
				Total	43%	🔴
			Te Waipounamu	Māori	48%	🔴
				Pacific	54%	🔴
				Non-Māori, non-Pacific	41%	🔴

[15] Latest planned care is for the Q4 period 1 April 2022 – 30 June 2022.

				Total	42%	●
Rates of access to a first specialist assessment	Patients waiting longer than four months for their first specialist assessment (FSA)	0% of people waiting longer than four months for their first specialist assessment	Northern	Total	26%	●
			Te Manawa Taki	Total	30%	●
			Central	Total	18%	●
			Te Waipounamu	Total	25%	●

Target focus	Target	Latest Actual[16]	
First specialist assessments per 100,000 people – crude rate	Demand-driven measure	Northern	9,993
		Te Manawa Taki	11,937
		Central	11,804
		Te Wai Pounamu	9,597

[16] Latest planned care is for the Q4 period 1 April 2022 – 30 June 2022.

Planned care activity

The most recent confirmed planned care activity data against plan is as at the end of August 2022. Local areas are increasing the volume of low complexity planned care (minor procedures), as these procedures do not generally require an inpatient admission. This was around 23% above target.

Inpatient surgical discharges for more complex surgery are below plan (around 17% below target). This was mainly because demand for acute care exceeded bed capacity, meaning planned care beds were used to accommodate acute patients.

Measure	April 2022	May 2022	June 2022	July 2022	August 2022
Inpatient Surgical Discharges	-3,929 against plan	-3,557 against plan	-2,828 against plan	-3,103 against plan	-5,311 against plan
	-26.8%	-20.0%	-17.5%	-20.0%	-16.4%
Minor Procedures	+1,952 against plan	+1,976 against plan	+ 2,163 against plan	+1,433 against plan	+3,895 against plan
	+22.9%	+19.1%	+22.9%	+18.3%	+23.2%
Total delivery against plan	**98.7%**	**98.9%**	**98.8%**	**92.4%**	**96.5%**

For the next quarterly report and beyond, we are aiming to include publicly-funded planned care that is being undertaken in private facilities.

Prioritisation process

Across Aotearoa, between 98-100% of patients are reported as being prioritised using nationally recognised processes and tools.

Standardisation of clinical processes will be enhanced through the implementation of some of the initiatives within the Reset and Restore Plan which was announced in October 2022.

Target focus	Progress Measure	Target (by region, by ethnicity)		Latest Actual[17]	Rating
Cancer treatment and elective surgery	100% of patients treated were prioritised using nationally recognised processes or tools	Northern	Māori	98%	
			Pacific	99%	
			Non-Māori, non-Pacific	99%	
		Te Manawa Taki	Māori	100%	
			Pacific	100%	
			Non-Māori, non-Pacific	100%	
		Central	Māori	100%	
			Pacific	100%	
			Non-Māori, non-Pacific	100%	
		Te Waipounamu	Māori	100%	
			Pacific	98%	
			Non-Māori, non-Pacific	100%	

[17] Latest prioritisation data is for the Q4 period 1 April 2022 – 30 June 2022.

Missed appointments for specialist care

The percentage of patients who do not attend appointments for specialist care range from 4-5% for non-Māori through to 17% for Pacific patients in the Central Region. Within the Reset and Restore Plan, several actions are being initiated to support patients to access their care and reduce missed appointments. There will be focused pieces of work in collaboration between the Te Whatu Ora Pacific Health team and Te Aka Whai Ora, over the remainder of the calendar year.

Target focus	Target (by region, broken down by ethnicity and treatment type)		Actual[18]
Missed appointments for specialist care	Northern	Māori	14%
		Pacific	15%
		Non-Māori, non-Pacific	5%
	Te Manawa Taki	Māori	15%
		Pacific	13%
		Non-Māori, non-Pacific	5%
	Central	Māori	13%
		Pacific	17%
		Non-Māori, non-Pacific	4%
	Te Waipounamu	Māori	13%
		Pacific	16%
		Non-Māori, non-Pacific	4%

Notes:

- data for Te Wai Pounamu excludes Southern local data for Central excl. Hutt Valley

[18] Latest missed appointment data is for the Q4 period 1 January to 31 March 2022.

Cancer treatment

What these measures mean

These targets reflect the expectation that patients with a diagnosis of cancer are treated quickly. While more than 85% of patients diagnosed with cancer receive their first cancer treatments within 31 days from the date of the decision to treat, no region is meeting the target of 90% of patients receiving their first cancer treatment within 62 days of referral with a high suspicion of cancer.

The lead agency for monitoring and reporting on hauora system performance in detecting and treating cancer is Te Aho o Te Kahu – the Cancer Control Agency. They provide a suite of tools on the quality performance of the system, which can be found at **Te Aho o Te Kahu - Cancer Quality Performance Indicator Programme**. We will work with Te Aho Te Kahu to agree on what, how and where cancer treatment should be reported on from Quarter 2.

Target focus	Progress Measure	Target (by region)	Actual – Q1	Q1 rating
Cancer treatment	90% of patients to receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks.	Northern	83%	
		Te Manawa Taki	77%	
		Central	80%	
		Te Waipounamu	82%	
Cancer treatment	85% of patients receive their first cancer treatment (or other management) within 31 days from date of decision-to-treat.	Northern	85%	
		Te Manawa Taki	85%	
		Central	86%	
		Te Waipounamu	89%	

Cancer screening

What these measures mean

Bowel cancer screening has been identified as a Health System Indicator (HSI). Participation (coverage) is an important measure for determining the acceptability and reach of population screening programmes. Coverage and participation are based on the percentage of those eligible for a screening test, who have the test during a certain period. Coverage and participation are calculated on a rolling two- or three-year period up to the reporting date.

The national breast screening programme, BreastScreen Aotearoa, invites participants to have a screening mammogram every two years. The National Cervical Screening programme offers participants a cervical smear every three years. The bowel screening programme invites participants to return a completed FIT kit every two years, so participation counts invitations over a 2-year period. Both programmes have a responsibility under Te Tiriti o Waitangi to eliminate differences in screening coverage between Māori and non-Māori. Our equity targets also include eliminating equity gaps and reaching coverage targets for all. COVID-19 has disrupted and delayed the provision of all cancer screening services and Māori and Pacific have suffered a disproportionate burden of the COVID-19 pandemic. The rolling participation and coverage periods reported below include periods of significant disruption due to the pandemic.

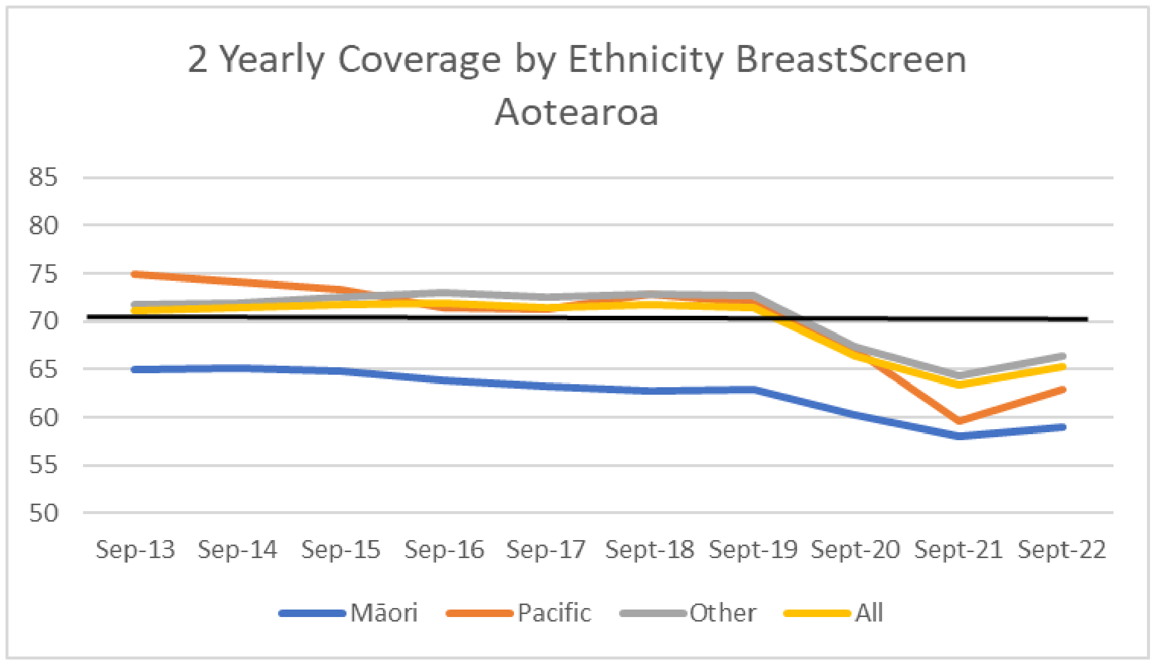
Quarter 2 priorities

- **Quarter 2 priorities will be focused on achieving equitable access to screening as a priority.**
- **Activities will include: the continuation of awareness raising campaigns for cervical screening; trialling regional campaigns using tools developed during the COVID-19 pandemic to spread the message about vaccines; investigating a hub model for Auckland region breast screening providers to support collaborative approaches to increase coverage in the region; and supporting Māori and Pacific participation in all cancer screening programmes, particularly in areas where coverage is below target and inequitable.**

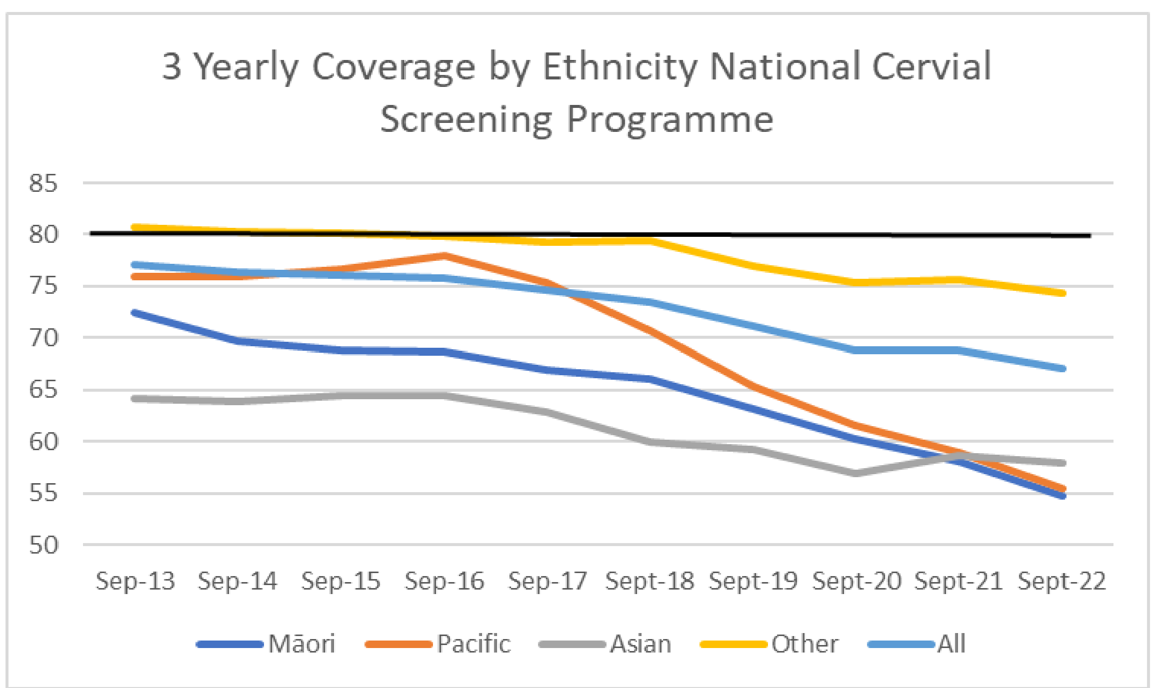
Target focus	Progress Measure	Target		Actual – Q1			Q1 rating
				July 2022	August 2022	September 2022	
Equitable participation across all cancer screening programmes	Breast screening coverage	70% of eligible Māori people screened for breast cancer in the last two years	Māori	59.0%	59.2%	59.0%	
		70% of eligible Pacific people screened for breast cancer in the last two years	Pacific	62.8%	63.3%	63.0%	
		70% of eligible people screened for breast cancer in the last two years	Total	65.5%	65.6%	65.3%	
	Cervical screening coverage	80% of eligible Māori people screened for cervical cancer in the last three years	Māori	54.8%	54.7%	54.8%	
		80% of eligible Pacific people screened for cervical cancer in the last three years	Pacific	55.5%	55.4%	55.4%	
		80% of eligible people screened for cervical cancer in the last three years	Total	66.9%	67.0%	67.1%	
	Bowel screening participation[19]	60% (at least) of eligible Māori invited return a completed FIT kit in the last two years	Māori	48.7%	-	-	Q1 data not available
		60% (at least) of eligible Pacific peoples invited return a completed FIT kit in the last two years	Pacific	39.2%	-	-	
		60% of eligible people invited return a completed FIT kit in the last two years	Overall	58.8%	-	-	

[19] July 2022 is the latest period for which bowel screening data is available. An update is expected in December 2022

Breast Screening Coverage



Cervical Screening Coverage



Mental health and addiction

What these measures mean

These measures provide assurance that we have equitable access to Mental Health and Addiction services. The key indicator in this set is Health System Indicator (HSI) - *'Under-25s able to access specialist mental health services within three weeks of referral'*. There are pressures on child and youth services, and some children and young people must wait before accessing specialist mental health services. The onset of serious mental illness mostly occurs before the age of 25, and crosses child and adolescent and adult service boundaries. It is important to focus on the specific needs of young people presenting with a first episode of illness. This indicator aims to lift performance and support more timely access for children and young people. The COVID-19 pandemic affected both service provision and the needs of young people who experience mental health challenges. Many local areas have reported increasing difficulty in retaining and recruiting a suitably qualified workforce. The challenges remain workforce supply and the ability to see people in a timely manner.

Commentary

The current quarter saw an improvement in the proportion of those aged under 25 years able to be seen by specialist mental health and addictions services within three weeks. Results for all population groups are above the target of 80%.

As at end of August 2022, 546,200 sessions had been delivered with an enrolled population coverage of 2.6 million people through integrated GP services.

There are some challenges with recruitment, and we are working closely with providers who have recently received more funding to grow staffing levels.

The programme is on track to deliver its intended milestones.

Quarter 2 priorities

- **Progress with planning to implement Budget 22 funding for increasing the capacity of child and adolescent specialist mental health and addiction services.**
- **Continue the ongoing phased roll out of youth primary mental health and addiction services and Integrated Primary Mental Health and Addiction services in primary care.**
- **Maintaining staff rates within 60-80% of the contracted staff across the four workstreams of the Access and Choice programme.**

Target focus	Target/ measure	Target (by ethnicity)	Actual – Q1	Q1 rating
Mental health and addiction services are available for those who need them	Number of mental health contacts	Māori	276,767	N/A – demand-driven measure
		Pacific	70,940	
		Non-Māori, non-Pacific	535,239	
		Total	882,946	
	Number of mental health bed nights	Māori	71,447	N/A – demand-driven measure
		Pacific	15,323	
		Non-Māori, non-Pacific	118,147	
		Total	204,917	
	80% of under 25-year-olds access specialist mental health or addiction services within three weeks of referral[20]	Māori	93%	
		Pacific	96%	
		Non-Māori, non-Pacific	91%	
		Total	92%	
	People served by specialist and NGO mental health services per 100,000 people	Māori	24,232	N/A – demand-driven measure
		Pacific	5,360	
		Non-Māori, non-Pacific	54,470	
		Total	84,062	

[20] Latest data for under 25-year-olds accessing mental health services within 3 weeks is the Q4 period 1 April – 30 June 2022

Developing the health workforce of the future

Quarter 1 progress

Transforming our health system is reliant on ensuring that our workforce is well-supported, with the right people with the right skills in the right places.

It has been a challenging winter, with the ongoing impact of COVID-19 and other illnesses putting significant pressure on our workforce. Quarter 1 has seen a focus on increasing the number of people coming into health as a profession. This includes early work with the education and training sector to grow domestic channels, alongside significant new initiatives announced to accelerate the inflow of staff into our health workforce, such as investments in return to nursing, support for internationally qualified nurses, and growth in domestic training for medical and nursing professionals.

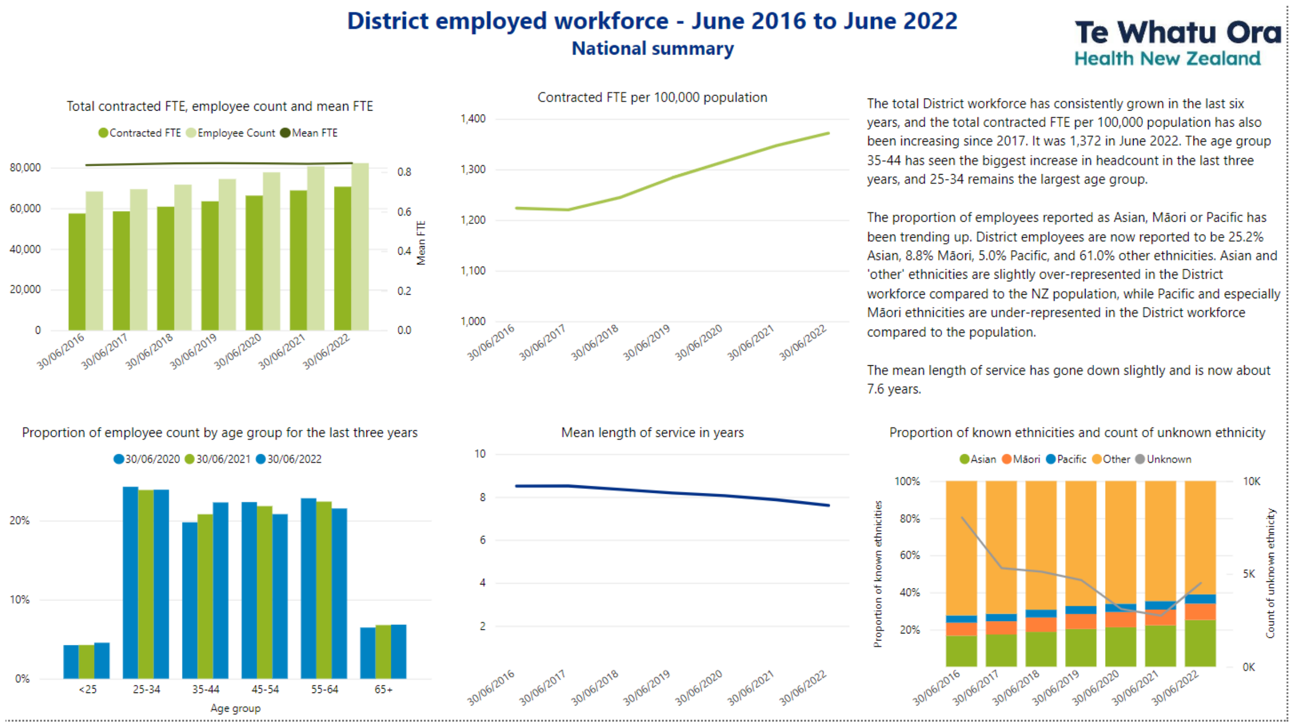
We expect an increase in overseas trained workers to help alleviate pressure over coming years, while investments in education and training increase and build a pipeline of domestically qualified people through training. During Quarter 1, we launched Round 3 of the Return to Nursing programme – which went live on 13 September 2022 and received 47 applications by the end of the quarter delivering support for Internationally Qualified Nurses (IQNs) to complete Competency Assessment Programmes (CAP) so they can practice in Aotearoa New Zealand, with 419 eligible registrations of interest received by 26 October 2022.

Priorities for Quarter 2 on

- **Continued work with immigration and education agencies and sectors to grow the flow of people into our health workforce – domestically and internationally.**
- **Engagement with our workforce and union partners on Te Mauri o Rongo | the Health Charter.**
- **Development of the Health Employment Relations Strategy.**

Workforce trends over time

To provide context for the health workforce, the dashboard below provides an overview of the local area workforce from June 2016 – June 2022, broken down by employment type, age and ethnicity, as well as mean length of service.



Workforce profile

The table below provides key workforce metrics as at 30 September 2022, providing data for the employed workforce from the local areas, Te Whatu Ora national office, Te Akai Whai Ora and seven Shared Service Agencies (SSAs) including total Full Time Equivalent [FTE] staff, percent by ethnicity (Māori, Pacific, Asian, and other), turnover, vacancy FTE and rate, sick leave rate and lost time to injury rate by the seven occupational groups.

From Quarter 2, data will include a comparison of key changes and accompanying commentary on the likely reasons behind any changes.

July - September 2022	Total FTE	Māori	Pacific	Asian	Other	Turnover	Vacancies (FTE)	Vacancy Rate	Sick Leave Rate	Lost Time to Injury (Rate)
Allied and Scientific	11,149	7.0%	3.5%	18.3%	71.2%	4.0%	1,307.1	10.5%	4.7%	5.3
Care and Support	7,211	17.2%	12.9%	24.0%	45.8%	4.6%	686.7	8.7%	5.3%	21.2
Corporate and Other	17,963	11.2%	7.2%	16.3%	64.9%	3.6%	1328.9	6.9%	3.9%	6.6
Midwifery	793	9.4%	1.3%	6.8%	82.5%	2.7%	237.6	23.1%	4.9%	0.0
Nursing	27,217	6.4%	3.8%	33.4%	56.4%	3.4%	2,802.7	9.3%	5.2%	17.1
Resident Medical Officer (RMO)	5,317	6.6%	2.7%	26.5%	64.1%				2.9%	2.4
Senior Medical Officer (SMO)	5,394	2.0%	1.0%	18.4%	78.6%	1.6%	508.1	8.6%	2.5%	1.1
Te Whatu Ora (incl former SSAs)	**75,044**	**8.4%**	**5.2%**	**24.3%**	**62.0%**	**3.5%**	**6871.0**	**8.4%**	**4.5%**	**10.9**

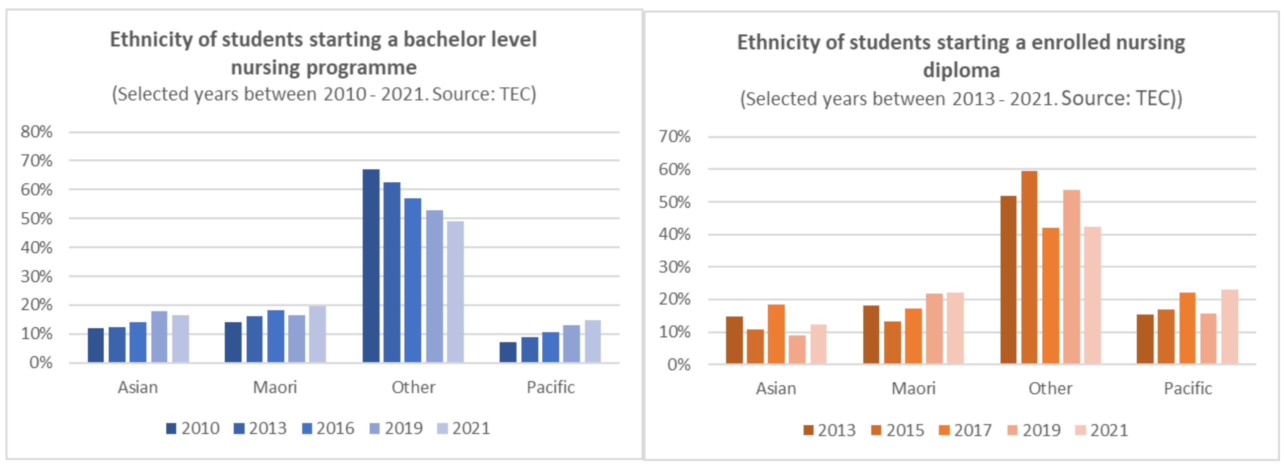
Notes:

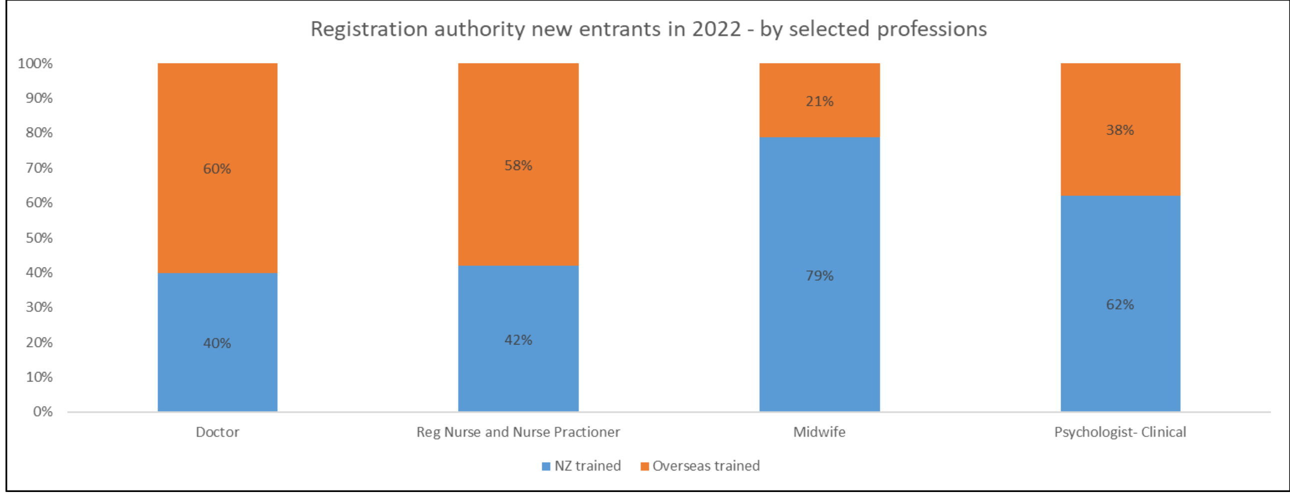
RMOs are not included in the turnover, vacancies and vacancy rate columns, as RMOs are typically managed differently since they rotate within and between areas during their training.

Lost time to injury is the number of incidences that result in lost work hours due to workplace injuries of illnesses. Ratio multiplied by 1 million to improve the comparability.

Supply and training pipeline

This slide provides a picture of our workforce supply pipeline over the past decade, to help contextualise the challenges we face in driving a more sustainable health workforce. In future quarters, we will endeavour to signal trends and activities in workforce supply and training; though the annual nature of many training intakes mean that data tends to be annual rather than quarterly.





Increasing student enrolment

There has been growth in numbers of new enrolments in both bachelor level nursing programmes and enrolled nurse diploma and an increasing percentage of these are for Māori and Pacific students. Visibility across other areas will be developed as other pipeline work progresses.

Snapshot of where trained

Regulatory Authority data has been used to show the composition of the health workforce broken down by NZ trained and overseas health professionals. This data is available across all registration authorities, and this is a snapshot of key workforce groups.

Workforce Taskforce

Te Whatu Ora has established a Workforce Taskforce to focus on ensuring we have the right people with the right skills in the right place – and a workforce which is Te Tiriti centred, focused on equity and reflects the diversity of the communities it serves.

The Workforce Taskforce has established a series of professional working groups focused on the pipeline for our key health professions – including how we recruit, develop, and retain our staff in a career in health. Opportunities we will be exploring through the Taskforce will include:

- Modelling workforce requirements across the health system.
- Agreeing prioritisation of training with the Tertiary Education Commission.
- Supporting return to practice initiatives.
- Enabling entry to health jobs at all stages of life.
- Exploring different employment models while training, including pay as you learn, internships, apprenticeships.
- Exploring financial support solutions for students through employment options, scholarships and bonding initiatives.
- Strengthening a wide range of training settings across the health system.
- Developing processes which support areas of greatest challenge for the current workforce, including Aotearoa New Zealand-based training programmes, training in place, financial incentives, extended scope of practice and flexible employment.

These will sit alongside and complement investments already underway in growing our workforce, including through immigration and return to practice settings.

Culture and engagement

Context

Strengthening our culture across the health system is an essential part of realising the potential of the health system. Our workforce is incredibly hard-working and has kept New Zealanders well through the COVID-19 pandemic and a challenging winter; we are focused on improving the experience of working in health, starting with culture.

Key activities in Quarter 1

- Engagement on Te Mauri o Rongo has commenced; work is underway with unions and focus groups representing key workforce groups to validate the foundations of Te Mauri o Rongo, and develop a suite of behaviours to translate the desired culture into ways of working for frontline staff.
- Initial rollout of an approach to support Te Whatu Ora leaders to lead through change.

Priorities for Quarter 2

- **Te Whatu Ora and Te Aka Whai Ora are working to develop and scope a pulse survey on culture and engagement for our directly employed health workforce, to occur before Christmas. This will give us a data baseline for culture moving into 2023.**
- **We expect to engage through Quarter 4 2022 and Quarter 1 2023, and release Te Mauri o Rongo (the Health Charter) by the end of Quarter 2023.**
- **This will be followed by an implementation approach to support the rollout of Te Mauri o Rongo across the health sector.**

Employment relations

Context

How we work with unions and our workforce is an essential part of how we strengthen our health system, make health a better place to work, and deliver on shared priorities like workforce supply and workforce development.

Key activities in Quarter 1

- We have successfully concluded bargaining with a number of groups, including several key APEX workforces.

- We have made significant progress in establishing new employment relations settings and institutions, including new union groups to support enduring, constructive engagement.

We have adopted consistent, nationwide approaches to our staff's employment where possible – including through use of national winter rates to support staff taking on additional shifts through the tough winter period.

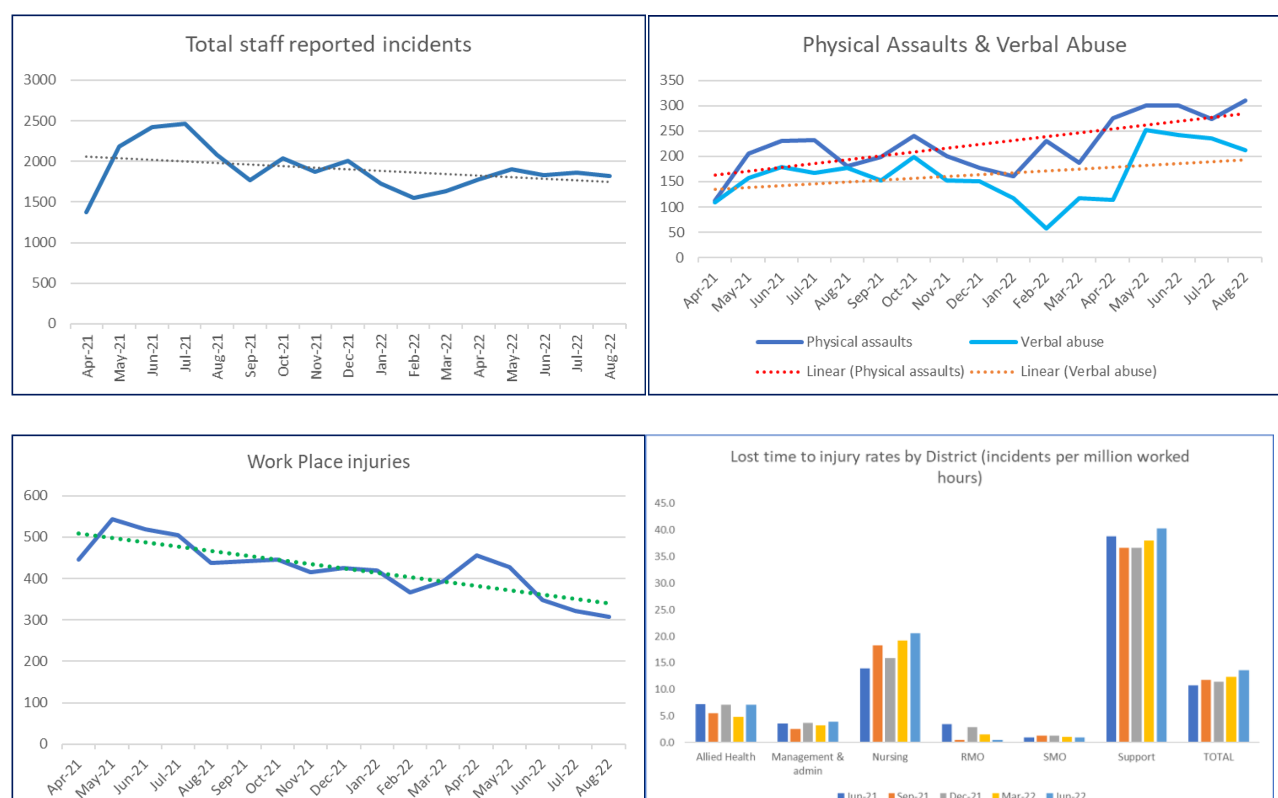
Priorities for Quarter 2 on

- **Te Whatu Ora is working to develop a Health Employment Relations Strategy (HERS) – with input from central and health agencies, and our union partners – to set out how we plan to approach our employment relations portfolio over the next two years.**
- **While we develop the HERS, we are working to:**
- **Ensure our approach to employment relations adopts interest-based methodologies and finds common ground with our workforce and union partners – including how we work together on Te Mauri o Rongo and culture changes, and the HERS.**
- **Prepare for significant upcoming bargaining events – including the New Zealand Nurses' Organisation Nursing and Midwifery collective agreement, which has just commenced.**

Health, Safety and Wellbeing

From a trend perspective there has been a steady reduction in staff reported incidents over the past 12 months, however it should be noted that this may be due to due to under-reporting across the system. Reporting relating to both *verbal abuse and physical assaults* continues to grow, while *workplace injuries* have been steadily declining over the past 15 months and we are seeing a positive trend.

Lost Time Injury Frequency Rates (LTIFR) are used to calculate how a company health and safety system is performing, by calculating the number of LTIs multiplied by one million, divided by the number of person hours worked in the period.



Occupational Health, Safety and Wellbeing

Te Whatu Ora's Occupational Health, Safety and Wellbeing performance indicators, alongside updates on key work underway are closely monitored by the Board's delegated subcommittee on Health and Safety.

There are a significant number of requirements on the organisation to undertake notifications to WorkSafe under the Health and Safety at Work Act. A summary of notifiable incidents and events that have occurred across the local areas is provided below.

Agreement has been reached to establish a tri-partite arrangement with WorkSafe, all our union health partners and Te Whatu Ora, to develop a robust and effective health, safety and wellbeing strategy, which will be proposed for endorsement by the Board early 2023.

The National Workplace Violence Workstream has been established with clinical and non-clinical members from across Te Whatu Ora. The aim of the group is to provide governance which includes a single workplace violence strategy, supported by policy, monitoring and reporting frameworks as well as an educational training programme.

Summary of Notifiable Incidents and Events by Area for the Quarter Ending 30 September 2022

Local Area	No. of Events	Provisional Improvement Notice (PIN) Issued
Te Toa Tumai Auckland	3	
Counties Manukau	1	
Hauora a Toi Bay of Plenty	3	
Te Pae Haouora o Ruahine o Tararua Mid Central	1	
Te Matu a Maui Hawke’s Bay	1	
Capital, Coast and Hutt Valley	5	4

General updates and work in progress

Te Whatu Ora Vaccination Policy – following the lifting of the Health Order, a working group has been established to develop a single vaccination policy for all new and current staff.

The Fatigue Minimisation and Management Steering Group has been established to identify the causes of, and minimise the impact from, fatigue more effectively.

Interim Occupational Health & Safety Leadership Structure has been established to support the National Lead to accelerate priority activities including a detailed gap analysis of current processes across the motu.

An interim Occupational Health, Safety and Wellbeing Leadership Team appointed in September 2022

An interim Occupational Health and Safety Risk Lead has been appointed to bring together a more standardised approach to the assessment of occupational health and safety risks to enable a more mature and consistent approach to reporting in the future

Quarter 2 priorities

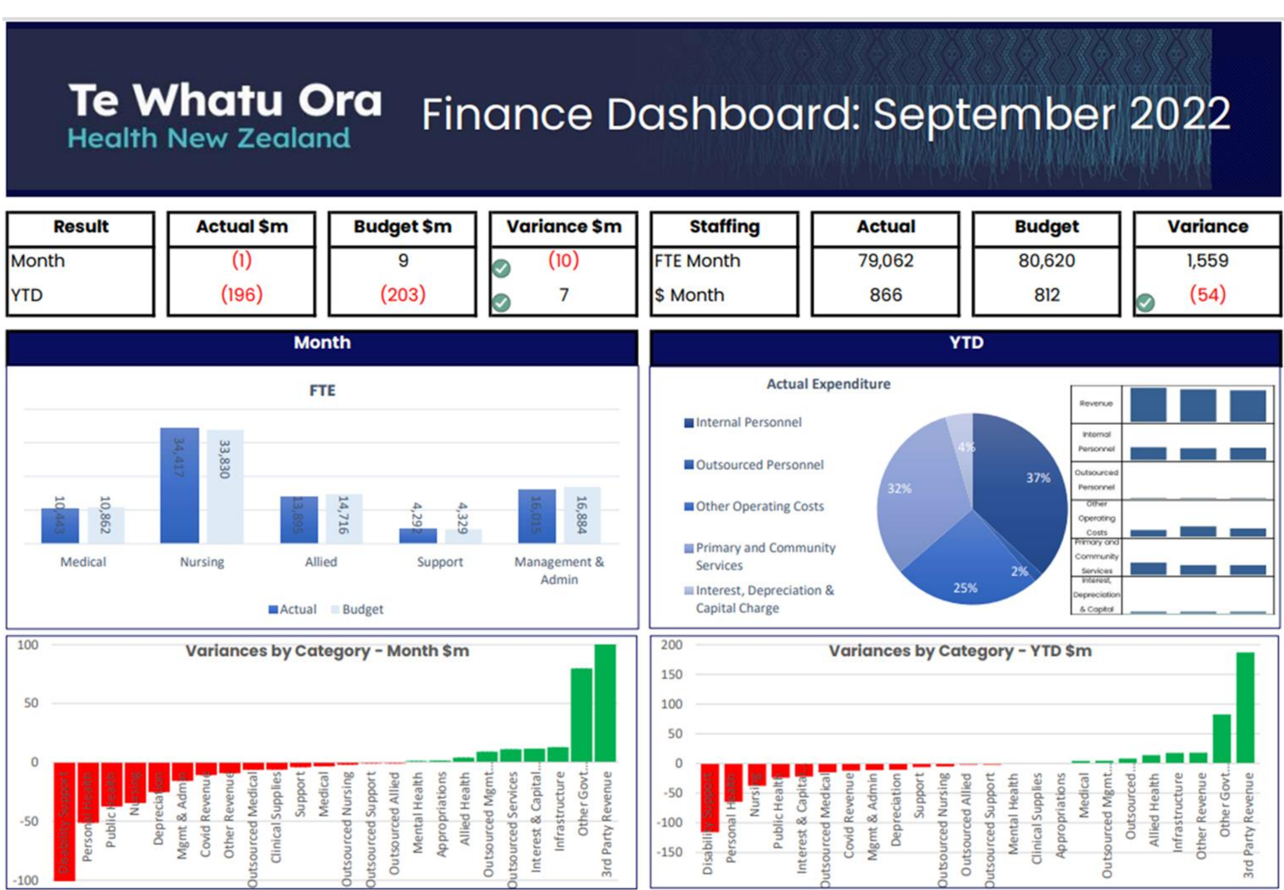
- **Completion of an Occupational Health and Safety gap analysis of current processes and service functions across the Te Whatu Ora areas**
- **Undertaking a discovery process to identify wellbeing initiatives, strategies and frameworks**
- **Designing and developing a transitional and future occupational health, safety and wellbeing operating model and organisational structure**

A financially sustainable health sector

Key points from Quarter 1

- Te Whatu Ora is currently on track to deliver within budget for 2022/23.
- Additional costs for activity for COVID-19 response and ACC were funded through extra revenue.
- Costs for staff overtime to cover sickness and vacancies, plus an additional public holiday have been absorbed within budget.
- Detailed financial reporting on expenditure for specific services and initiatives is in development and will be available and reported on from Quarter 3 onwards.
- Work continues on digital and capital projects, alongside the development of milestones for reporting from Quarter 2 onwards.

A table on progress implementing Budget 2022 initiatives and future milestones is also included.



Te Whatu Ora Financial Performance

Year-to-date financial performance to 30 September 2022

- As at 30 September 2022, Te Whatu Ora financial performance is $7m favourable to budget.
- Revenue has been above budget for the first quarter for COVID-19, disability services and services funded via ACC. Costs have also been above budget in relation to these services, but the additional revenue has fully offset the additional costs.
- The statutory holiday observed in relation to the Queen's passing is an unbudgeted cost that has been absorbed. It is estimated that the cost of the statutory holiday was slightly more than $30m in total, largely in Nursing staff.
- Clinical staffing categories continue to show significant vacancies. However, vacancies do not translate to financial underspends, as overtime payments and allowances earned by staff working extra hours to cover the FTE (and illness-related shortfalls in staffing) offset lower salary costs.
- Infrastructure and non-clinical supplies are $13m favourable, mainly related to COVID-19 underspend against this category. The $1.4bn COVID-19 budget was transferred to Te Whatu Ora very late in the budget process, and budgeting against spend categories could only be estimated at high-level.

- Primary and Community spend is $204m over budget – this is mainly due to COVID-19 spend incurred within local areas that can be directly invoiced to the Ministry of Health, over and above the transferred COVID-19 budget – note these costs are offset by increased revenue. Also, there is spend above budget and offsetting revenue from Whaikaha | Ministry for Disabled People (appears in other government revenue) for Disability Support Services.
- Depreciation costs are unfavourable, because of recent building revaluations – the depreciation impact is covered centrally in later months.

Risks to the annual operating result exist, in relation to the pending finalisation of the eNursing MECA negotiations, ongoing COVID-19 and winter illness pressures, supplier cost pressures, and a lack of visibility of transferring Ministry of Health third-party contract commissioning.

Te Whatu Ora Health New Zealand Group $Millions	Year to Date Total Actual	 Total Budget	 Variance	Annual Budget
Revenue				
Appropriations	4,848	4,848	0	20,424
Covid Revenue	1,051	864	187	1,420
Other Government Revenue	542	460	82	1,843
Third Party Revenue	17	29	(12)	74
Other Revenue	103	85	18	877
Total Revenue	**6,560**	**6,285**	**275**	**24,638**
Expenditure				
Internal Personnel				
Medical Personnel	694	698	4	2,839
Nursing Personnel	948	910	(38)	3,800
Allied Health Personnel	336	350	14	1,376
Support Personnel	84	78	(6)	313
Management & Admin Personnel	432	421	(11)	1,610
Subtotal	**2,494**	**2,457**	**(37)**	**9,938**
Outsourced Personnel				
Medical Personnel	41	26	(15)	102
Nursing Personnel	8	3	(5)	10
Allied Health Personnel	4	2	(2)	9
Support Personnel	3	2	(2)	6
Management & Admin Personnel	57	61	4	197
Subtotal	**114**	**93**	**(20)**	**324**
Other Operating Costs				
Outsourced Services	439	448	8	1,333
Clinical Supplies	817	816	(0)	2,264
Infrastructure & Non-Clinical Supplies	436	454	18	1,630
Subtotal	**1,692**	**1,718**	**26**	**5,227**
Primary and Community Services				
Personal Health PEP	1,244	1,180	(64)	4,843
Mental Health PEP	154	154	(0)	692
Disability Support Services PEP	580	556	(24)	2,221
Public Health PEP	171	55	(115)	273
Subtotal	**2,148**	**1,944**	**(204)**	**8,029**
Interest, Depreciation & Capital Charge				
Depreciation	204	194	(11)	791
Interest & Capital Charge	104	82	(22)	329
Subtotal	**308**	**276**	**(33)**	**1,120**
Total Expenditure	**6,756**	**6,488**	**(268)**	**24,638**
Net Surplus/(Deficit) from Operations	**(196)**	**(203)**	**7**	**0**

Digital investment

The interim Government Policy Statement for Health included several high-level objectives, for which milestones will be developed and subsequently reported on. The table below sets out key activities for Q1 where applicable, and notes planned activities for Q2 (up to end December 2022). These will be reported on in the next quarterly report.

Objective	Status
Develop and implement a national plan to create consistency in data and digital capability across Te Whatu Ora.	No milestone for Q1. For Q2: The scope of a national plan is being determined and progressed in conjunction with the wider workforce capability team.
Improve digital access to primary and mental health care to improve access and choice, including virtual after-hours and telehealth, with a focus on rural communities.	After-hours telehealth solution for 191 rural general practices has been scoped and agreed. Procurement processes are underway.
Create a national platform for analytics with a common data model and near real-time operation encompassing hospital operations, public health, primary care and workforce.	No milestone for Q1. For Q2: The Rapid National Data Automation Project has, to date, automated and combined the following datasets to give an up-to-date view of health pressures across the system: admissions to hospital, emergency department presentations, hospital ward nurse resourcing (showing ward occupancy and shift with lower than required nursing hours). New dataset automations are in progress: Waitlists for procedures, outpatient first assessments, colonoscopy, gastroscopy and retinal screening; and theatre events and sessions (acute and planned). A discovery phase, looking at the principles, scope and design considerations, for a national data platform (model), has been completed. An RFP for a design partner is being prepared (release subject to ELT and Board approval).

Deliver approved digital capital projects, working to delivery plans	A review of all current and planned data and digital investments is currently underway, to ensure that the investments are focused on strategically critical areas in line with the objectives of Pae Ora, Te Pae Tata and health reform objectives and the five system shifts. Additionally, the review is intended to look across the full picture of all data and digital investments across the country and identify opportunities to reduce duplication and consolidate initiatives where appropriate. It is expected that the first outcomes from this will be included in Q2 reporting.

Capital investment and procurement

Infrastructure Investment

The Infrastructure and Investment Group (IIG) is responsible for monitoring the health sector's capital projects that require Crown funding or exceed $10 million in capital cost. The IIG is monitoring 103 projects across the local areas with combined multi-year Crown funding of $6.677 billion.

Key results for the period include:

a) $1.821 billion of actual capital project expenditure had been incurred as of 31 August 2022 by the local areas against these 103 projects.

b) As at 31 August 2022, $1.59 billion in funding has been reimbursed to local areas for health capital expenditure.

Performance reporting

Health capital projects report to the IIG on either a monthly or quarterly cycle. This performance report is based on the most recent assurance reports. The dates for these reports are:

a) 35 projects that report monthly as at 31 August 2022.

b) 49 projects that report quarterly as at 30 June 2022.

c) 18 projects have been completed and are no longer required to provide an assurance report.

d) 1 project has not established its reporting cycle yet.

Reporting in Quarter 2

We expect to further develop the capital investment and procurement milestone reporting in time for the Quarter 2 report.

Budget 22 Investments Update

Initiative	COMPLETED Milestones and their completion dates (as at 16 September 2022)	Next milestone	Next milestone - Due date
Addressing the Burden of Diabetes for Pacific Communities		Planning for this initiative is currently underway. During Q1 2022/23 the team will establish a governance group to oversee the approach to commissioning this project.	
Additional Funding for Emergency Air Ambulance Services		Executed 4-year Air Ambulance Services Agreement.	1-Nov-2022
Additional Funding for Emergency Road Ambulance Services	Executed 4-year Road Ambulance Services Agreement. 1/07/2022	Completion of implementation plan and resource allocation plan. i.e., recruitment and capital investment timing, also onboarding of people, vehicles and associated equipment at region/area level.	1-Jan-2023
Capital for Health Sector Infrastructure		Refer separate capital reporting	
Dementia Mate Wareware Action Plan – Implementation Support Funding		Implementation planning completed	30-Nov-2022

Initiative	COMPLETED Milestones and their completion dates (as at 16 September 2022)	Next milestone	Next milestone - Due date
Improving Access to Primary Health Care Services for Transgender People	Initiative has been handed over from MoH to HNZ for implementation. This occurred on 1 July 2022 and an implementation plan will be developed	Develop implementation plan and commence procurement process for first pilot practices	31-Dec-2022
Increasing Availability of Specialist Mental Health and Addiction Services	Te Whatu Ora is on track with the milestones outlined. We are well underway with preparatory work which is continuing	Complete implementation planning and preparatory work to enable funding allocation to be prioritised considering population need and the spread of existing resources (First half of 2022/23)	31-Dec-2022
Mana Ake – Expansion of Mental Wellbeing Support for Primary and Intermediate School Students	Meetings held with leaders from all 6 areas to discuss indicative funding allocation and next steps (completed by 30 June)	Local leaders meet with their stakeholder governance group to discuss funding allocation and next steps and then provide feedback to Te Whatu Ora - Health New Zealand Local leaders meet with their stakeholder governance group to discuss funding allocation and next steps and then provide feedback to HNZ	30-Oct-2022

Initiative	COMPLETED Milestones and their completion dates (as at 16 September 2022)	Next milestone	Next milestone - Due date
Payment to Family Members for Support Services		31 December 2022 - New policy implemented	31-Dec-2022
Pacific Primary and Community Care Provider Development	Applications to the fund closed September 2022.	Contracts with providers expected to be in place by January 2023	31-Jan-2023
Piki – Continuation of Integrated Primary Mental Health and Addiction Support for Young People in Greater Wellington		Contract negotiations to support ongoing service delivery	31-Oct-2022
Population Health and Disease Management Digital Capability	Finalise target state platform architecture for disease management ecosystem – September 2022.	Provide progress update with plan, including key milestones, risks and mitigations.	11-Nov-2022
Service Integration for Locality Provider Networks		Service delivery for 9 locality prototypes plus ~10 Year 1 locality sites in full flight	1-Jan-2023

Initiative	COMPLETED Milestones and their completion dates (as at 16 September 2022)	Next milestone	Next milestone - Due date
Well Child Tamariki Ora – Continuation of the Enhanced Support Pilots		Approved work programme for Kahu Taurima that responds to the iNZHP	1-Dec-2022

Laying the foundations for the ongoing success of the health sector

The interim Government Policy Statement outlines four metrics that help lay the foundations for ongoing success in the health sector:

1. Health entities are clear about their own and other entities' roles and responsibilities, and are delivering to these
2. Experience of primary health care and adult inpatient health services measured across demographic groups using patient experience surveys
3. Proportion of entities that have been assessed against the Consumer Engagement Quality and Safety Marker; and of those, the proportion that have been assessed at Level 3 or 4
4. Proportion of medical appointments completed through digital channels (initially outpatients and expanding to include general practitioner appointments when data is available)

Progress in Quarter 1

The context and embedding te Tiriti o Waitangi sections outline progress on the first measure. As noted in earlier sections, further work is planned to develop our understanding and use of patient experience as a measure of performance; and provide a clearer picture of quality and safety in future reporting.

The announcement in Q1 of a National Director, Improvement and Innovation, provides a focal point for delivery against these measures.

Quarter 2 priorities

- **The initial focus of the National Director, Improvement and Innovation is on establishing a team to support the delivery group to conduct a stocktake of current innovation activities across Te Whatu Ora. This will identify all activities in the system that contribute to improvement, so they can be shared across the organisation. The second priority is developing a horizon-scanning function to highlight worldwide best practice, including how innovation initiatives have been implemented, so that these can be considered for application in Aotearoa New Zealand.**
- **We expect to provide more detail on proposed metrics for the ongoing success of the health sector, as well as progress in implementing changes set out in Te Pae Tata in the next quarterly report.**

Environmental sustainability and climate resilience

The Environmental Sustainability and Climate Resilience (ESCR) focus covers three key areas – health system decarbonisation, environment in all practices, and health system resilience and adaptation

Decarbonisation

Emissions reporting key objective: Set Greenhouse Gas (GHG) baseline FY22/23

- The table below on GHG emissions shows most up to date emissions reporting of annual data to year-end FY21/22. As illustrated, 14 of 36 business units (incl. SSAs and wholly owned subsidiaries) have year-end data available
- Only 2 of 36 business units are currently reporting emissions monthly/quarterly
- Working on national data sources with expectation to have key emission sources available (e.g., energy, fuels) for Q2 subject to emissions reporting tool procurement

Energy transition key objectives: 25% GHG reduction by 2025 | remove all coal boilers by 2025

- Coal boiler transition implementation planning in progress. Intention for all coal boilers to be phased out by 30 June 2025.

- Programme Business Case for national approach to energy transition due Q2. Expected to confirm and enable application of remaining State Sector Decarbonisation Fund (SSDF) notional allocation of $38M

Resilience and adaptation

- Work is underway on the Health National Adaptation Plan (HNAP) with Te Whatu Ora providing advice to Manatū Hauora.
- Climate Health Action Plans (CHAP) are the responsibility of Te Whatu Ora. Workshops will commence early 2023 with key internal stakeholders including emergency management, public/population health and ESCR SMEs.

Privacy, government services and risk

Privacy

- Reported numbers are relatively stable, with a range of 65-72 reported breaches per month. While these numbers appear low for an organisation with over 75,000 staff, they may well increase in 2023 following the introduction of a shared reporting tool and better privacy awareness across Te Whatu Ora.
- 208 privacy breaches were reported this quarter, of which 20 met the criteria requiring notification to the Office of the Privacy Commissioner.
- Better reporting will allow targeted mitigations and education.
- Themes include emails being sent to the wrong person or misplaced/misfiled physical records. To address these issues, a range of new email controls (Data Loss Protection misuses, are planned.
- Audit and access controls will be assessed for all new or updated systems through a Privacy Impact Assessment. With a privacy team now in place at Te Whatu Ora, work on this will progress as a priority.

Government services

- 831 Official Information Act (OIA) Requests for Health were received this quarter: 458 at local areas, 21 at National Office and 352 managed by Manatū Hauora.
- Common themes are wait times for different services, board minutes/agendas, workforce stats/issues

- 11 Ombudsman complaints - 3 deemed delays and the remainder a mixture of OIA decisions and Ombudsman Act.
- For the period of August and September 2022, 487 Written Parliamentary Questions (WPQs) were processed, which represented 70.2% of all Health sector WPQs. (Data for July 2022 is not included, as manual processing at that time means the data is unreliable).
- Trends for WPQs are largely related to mainstream news items. Recent questions include several questions about hospital waiting times over recent years.
- This quarter, Ministerial / direct reply to correspondence has been managed and processed by the Manatū Hauora, with a graduated handover of all work agreed over September and October 2022. We have seen a significant increase in work being processed throughout October 2022 and expect this number to climb as BAU work is handed over from Manatū Hauora.

Risk

Understanding and managing risk is a key aspect of high-quality health system performance management. The table below provides an overview of key areas of risk in the health system, and management activities to address those risks.

Risk Description	Key Management Activity
Delivering Health Reforms	
Te Whatu Ora is unable to deliver the transition, associated culture and accountability change, and the benefits of the health sector reforms at the scale and pace expected.	• Delivering the performance targets outline in Te Pae Tata – Interim New Zealand Health Plan (October 2022) and the interim Government Policy Statement on Health 2022 – 2024 will start to realise the benefits of the health reforms • Change and transformation programmes underway to support the shift from 29 entities to one organisation capable of achieving performance targets
Workforce Capacity and Capability	
Te Whatu Ora does not have the workforce capacity to deliver healthcare and services to the community	• Establishment of Workforce Taskforce Group • Delivery of Planned Care Taskforce report with 101 recommendations

	• Development of retention strategies for high-risk areas • Delivery of Budget 22 workforce development initiatives, including short-term interventions targeting the immigration pipeline
Clinical Practice Quality	
Te Whatu Ora is unable to deliver consistent high-quality services and care to the community	• Short-term and long-term service planning • Short-term support within and between regions • Renewed focus on 'whole of system' flow including enhanced primary care, focus on ED and front of house response as well as timely discharge back to community
Equitable Health Outcomes	
Te Whatu Ora does not have clear targeted and regularly monitored strategies, plans or programmes supported across the health sector to deliver equitable health outcomes for all New Zealanders	• Delivery of Te Pae Tata – Interim New Zealand Health Plan (October 2022), which includes actions to improve equity for a range of population groups • Development of diverse and inclusive health workforce
Financial Sustainability	
Fiscal losses occur, resulting in pressure on funding the reform change programme	• Business case approval process established for new initiatives, capital projects and other changes. • Detailed costing of all proposed policy decisions • Advice to Ministers on the end of COVID-19 funding (provider risk, financial analysis and reprofiling, and costing beyond December 2022) underway • Revised budgeting and internal financial reporting processes to support the new organisational structure
Health Safety and Wellbeing	
Te Whatu Ora is unable to manage, monitor or respond	• Recruitment strategy to improve staffing levels

to the health, safety and wellbeing of its staff and visitors to its facilities	• Workplace Violence Prevention strategies including de-escalation training for staff • Strong partnership approach with Unions
Digital Systems and Service Enablement	
Te Whatu Ora does not have a clear strategy to maintain current systems or enable investment in technology to meet future demand and models of care	• Maintenance of existing technology • Operating system and Database Remediation projects • Investment in new enabling technologies • Strategic partnerships with key vendors
Infrastructure and Asset Management	
Te Whatu Ora does not understand the nature or condition of its infrastructure and assets to support future planning for maintenance and investment	• Align Clinical Service Planning with Capital Investment to ensure the physical structures are in place to support the service delivery • Develop high-level national / regional / local service medium and long-term masterplans • Development of Asset Management Plan

Appendix 1: Performance by region

Northern Region summary and highlights

Summary

This quarter has been challenging for the Northern region due to high hospital occupancy and staff pressures. However, the region continues to advance the regional service plan and is making good progress in addressing inequities for Māori and Pacific, although there are some key equity risks that require focus, in particular with childhood immunisation rates.

Quarter 1 key highlights

- A regional approach to equity prioritisation is being progressed and this is regularly profiling key equity gaps. Over recent months the ESPI compliance rates between Māori and non-Māori have narrowed and almost closed for FSAs.
- The region has worked effectively to support the National Planned Care Directive with a reduction in those waiting fewer than 365 days for treatment and for a First Specialist Assessment by about 50% during August and September.
- The Te Whatu Ora Northern Region Support Services has been actively involved in the submission to the Health Select Committee on Alcohol BYO at Race-day events and the provision of advice to PHA on the Smokefree Environments and Regulated Products Amendment Bill.
- Solid progress has been made towards meeting the planned care directive for patients waiting > 12 months on outpatient and treatment waitlists. The majority of patients still waiting > 12 months are in the Te Tai Tokerau area and work is underway at Te Tai Tokerau to identify what additional resources are needed to address these waiting lists and how the region can support this.
- All areas are seeing vacancy pressure across services specifically General medicine RMOs, ED nursing, Midwifery, MITs and anaesthetic technicians and Specialist Mental Health Services. Recruitment is ongoing across all areas, and we are working with the

Workforce Taskforce to establish sustainable workforce development with a focus on building our own and supplementing with an international workforce in the meantime

- The Interim Regional Director was appointed, replacing the previous Interim Regional Director who was appointed National Director, Hospital and Specialist Services in Te Whatu Ora. We also welcomed the appointment of Interim Te Aka Whai Ora Regional Director, of Ngāpuhi descent and a whāngai of Ngāti Kahungunu.

Northern Region key risks

Risk area	Description	Mitigation
Public Health	Childhood immunisation rates declined substantially since the start of the COVID-19 pandemic (67% vs 80%) and particularly for tamariki Māori (30% vs 62%). While the figures are concerning, the declining rates is due to tamariki who have had their first dose not getting their second, then those who have had their second not getting their booster.	The Metro Auckland Immunisation Governance Group has been established. The mandate is to focus primary and community care efforts on achieving equity and high vaccination coverage and leverage immediate opportunities, in alignment with the National Immunisation Taskforce.
Mental Health	The region continues to fall short of national mental health targets. Achievement for young Māori is below that for Pacific and other ethnicities.	Long-standing high workforce vacancies are a significant constraint National work focused on upskilling the existing workforce and strengthening the recruitment pipeline will help address this issue. A region-wide daily and weekly acute Mental Health inpatient dashboard has been developed to provide visibility of capacity across the region's acute inpatient units.
Cancer Treatment	The region met Faster Cancer Treatment (FCT) national targets this quarter. However, achievement is inequitable in some areas for Māori (Te Tai Tokerau) and Pacific (Waitematā and Counties Manukau).	The Regional FCT Steering Group will continue to work to achieve FCT targets and address inequities. Counties Manukau are working on improvements to improve low treatment rates for

Risk area	Description	Mitigation
		gynaecological cancer. Work is being undertaken by radiation oncology to reduce the wait time to FSA.
People	The midwifery workforce continues to experience high vacancy rates, especially employed midwives. All areas now demonstrate adverse outcomes where contributory factors include understaffing within midwifery and medical teams.	The region is working on initiatives to stabilise the workforce while national programmes of work are being developed by the National workforce taskforce.
People/ financial	The risks related to workforce pressure and fatigue continue, with particular pressures in nursing, allied health and data and digital. This reflects a combination of sickness/ absence and challenges recruiting to roles where pay rates are falling below competitive market rates.	The Auckland metro region has launched a recruitment site to attract international and domestic healthcare professionals to Auckland and there are a number of national workforce workstreams underway, which the local teams are contributing to.
People	Nursing shifts below target regionally have been approximately 45% over the last month with a very slight improvement compared with the previous month. We expect the region's demand, capacity and resourcing position to remain challenging due to ongoing staffing vacancies.	The region is prioritising national and local workforce initiatives to recruit to nursing vacancies
Financial	Significant cost escalations of up to 40% above budgeted figures continue to impact the region's in-train and planned/approved Capital Programme.	The region is reviewing a range of options, including re-prioritisation to manage these cost-related issues.

Te Manawa Taki Region summary and highlights

Summary

To address the significant demand pressures and staff sickness rates impacting the health system across the region this quarter, Te Manawa Taki has strengthened its coordination and collaboration through its interim Regional Leadership Team, supported by a Regional Coordination Centre. This has enabled a number of prioritised regional initiatives to progress at pace, whilst maintaining strong operational grip over system performance.

Quarter 1 key highlights

- A Regional Integrated Operations Centre (IOC) has been established to monitor and support the flow of patients between secondary and tertiary care and the community, and to enable early interventions to assist hospitals where there are local capacity/delivery challenges. Consistent hospital escalation statuses have been implemented, with dedicated Planning and Intelligence support from the Regional Coordination Centre supporting the Regional IOC.
- Good progress has been made in implementing the national Planned care directives.
- A Regional clinical services and capital programme has been established to design and implement consistent, whānau centred clinical pathways to improve equity, and access across Te Manawa Taki. This will initially focus on five priority services – critical care, mental health, renal, cardiac and cancer – and help develop a capital planning roadmap for the TMT region that is informed by clinical services.
- The Regional Coordination Centre has supported the interim Regional Leadership Team to help meet the initial five regional priority areas issued in July 2022. This has included establishing and running a Regional Incident Management Team (IMT) to oversee the seasonal pressures response, implementing consistent workforce redeployment processes, and managing the transition of COVID-19 response functions across Te Manawa Taki.

Te Manawa Taki Region key risks

Risk area	Description	Mitigation
Public Health	Childhood immunisation rates across Te Manawa Taki have been adversely impacted by the COVID-19 pandemic and continue to decline across most areas. The immunisations equity gap has also increased over this time period, with the relative equity gap for Māori 5-year immunisations in Te Manawa Taki declining from 100% in July 2019 to 83% as of the current quarter. While the figures are concerning, the declining rates is due to tamariki who have had their first dose not getting their second, then those who have had their second not getting their booster.	A regional immunisations taskforce has been established to explore and implement initiatives to help address this, focusing on new service delivery models and greater whānau engagement
People	Underlying workforce vacancies continue to pose significant service delivery risks, with a 21% midwifery vacancy across the region causing particular challenges. Incident rates caused by inadequate resourcing or unfilled shifts are particularly high (>20 incidents per 1,000 employees) at Lakes and Taranaki.	A revised, consistent regional workforce redeployment process has been implemented to help mitigate the risks posed by this.
People	The risks related to workforce pressure and fatigue continue, with particular pressures in nursing, allied health and data and digital. This reflects a combination of sickness/ absence and challenges recruiting to roles where pay rates are falling below competitive market rates.	Regional senior HR managers regularly explore options to implement staff wellbeing measures, and Te Manawa Taki is actively involved in national bargaining discussions to help address uncompetitive pay rates.
Financial	Financial risks for ongoing ability to provide access to strong, equity-led COVID-19 response for its communities throughout the recent surge in cases, as	Regional COVID-19 transition is being managed by the Regional Coordination Centre. Key roles and provider contracts within

Risk area	Description	Mitigation
	planned funding ceases from January 2023.	each area have been. These contracts will be extended in the short term, pending longer term funding decisions.
People	Many staff in key hospital and regional leadership roles leaving the organisation or moving to new roles over the transition, which presents a risk to service continuity.	The impact will be managed over time through interim and substantive replacements.
Financial	Financial variance within some areas – notably Taranaki and Bay of Plenty.	All areas are managing financial variance through savings programmes and monthly performance monitoring. Financial diagnostic work has recently been commissioned for Taranaki, in conjunction with the National Te Whatu Ora CFO.

Central Region summary and highlights

Summary

Quarter 1 has been challenging for the Central region as the region manages a further surge in COVID-19 and ongoing workforce pressures. The region is advancing critical areas of work in particular a comprehensive programme for planned care, initiation of work to develop a regional clinical services plan and good progress in our child wellbeing and clinical network programmes which all have a focus on addressing inequities for Māori.

Quarter 1 key highlights

- Te Wao Nui (New Children's Hospital) in Wellington opened on Monday 17th October – This included Children's Clinics, Child Development Service, Allied Health Therapy Clinics, Child and Family Safety Service, and Community Nursing Team teams. Still to move are the Medical Children's ward and Wahi Tamariki (ED Paediatrics) when level 4 of the building becomes available.
- The establishment of a regional obstetrics and gynaecology network which is focusing on implementation of the maternity clinical information system, providing input into the Central region planned care work to address a single view of waitlists, support for the appointment of an additional training position for the region initially located in the Wairarapa area to provide immediate support for sustainability, and work to address access of, eligibility to, and funding for ultrasonography services in the region.
- A central region clinical board has been established and ToRs are currently under development which are aligned to national work.
- Planned care programme in place to address waiting lists and the region is continuing to hold steady in this space. The programme is focusing specifically on dental, laparoscopic cholecystectomy, orthopaedics and ophthalmology which is a vulnerable service across most of the Central region.
- A programme manager has been appointed and work is progressing to develop a Central region clinical services plan. A scope and procurement plan has been drafted which will be discussed by the Central Region Leadership Team on 7 November.
- Regional mental health and addiction programme confirmed by Central Region Mental Health Leadership Group which will focus on governance and leadership, learning and development, regional specialist service enhancement, development of a regional mental health and addiction dashboard, valuing lived experience and innovation and improvement.

- The Central region cardiology programme is progressing with an implementation plan to work towards a contemporary model of cardiac care in the Central region with outsourced work completed and a final report received by Synergia.
- Te Whakahaere phase (Implementation phase) of the Whakapakari Hunga Tautoko Project is in progress. This phase focuses on the operationalising of the project solution including the employment of Regional clinical support/educator positions (as designed in the Te Waihanga phase) and establishment of MOU between Central Region providers and Te Whatu Ora.
- A Clinical Lead for the Achieving Kaumātua Ora work programme has been appointed. The Clinical Lead will provide up to 0.2 FTE through to July 2023. The Regional Geriatricians have developed a regionally agreed poster for Advance Trainees (AT) to present at the upcoming Australian New Zealand Society of Geriatric Medicine conference. The intent is to entice AT's to firstly consider our region but also grow the opportunity for ATs to experience a range of local opportunities.

Central Region key risks

Risk area	Description	Mitigation
People	The Capital/Property/Infrastructure teams are generally under-resourced, have high vacancy rates and are having challenges recruiting in the current market	High levels of outsourcing, deferral of work, ongoing recruitment
Financial	Continued cost inflation across capital programmes	Applying realistic contingencies, prioritisation and substitution of works to meet budgets
Data / People	Continued requirement to resource national data requests, impacting capacity for regional work	Working alongside teams to understand stretch points and try to align with others who may be able to support the work
Financial	Financial risks depending on availability of access to 2021/22 underspend and COVID-19 Relief Recovery Fund (CRRF)	Continue to link in with updates on the work around commissioning and the priorities identified for this funding and put forward Central region perspective and where funding could be utilised

Te Waipounamu Region summary and highlights

Summary

As a region we have faced some real challenges this quarter particularly around staff vacancies and illness. Despite these challenges we have continued to provide high level care to our patients. Progress is being made within the planned care space regionally with Nelson and Marlborough making positive steps in their planned care waitlist and South Canterbury continuing to support Ashburton, Southern and South Canterbury. We have also established a Planned Care Clinical Network Group to ensure we have clinical support and there is a real focus on equity.

Quarter 1 key highlights

- Equity improvements in cancer treatment is a main focus. A Hauora Māori Equity Toolkit checklist of suggested actions to improve Māori health equity in hospital departments has been developed by Te Whatu Ora Waitaha Planning and Funding public health physician, Clinical Lead Māori and a Professor from the University of Otago's Māori Indigenous Health Innovation (MIHI).
- Mental Health - time for change – Te Hurihanga implementation Programme in Southern is continuing with:
  - Establishment of 5 bed crisis respite facility in Dunedin
  - Ringfencing of $1m Time for Change for "By Māori and For Māori"
  - Commencement of collaborative design processes with locality groups to design local responses to local issues
  - Establishment of organisational development programme within MHAIDS
- In the innovation / Performance improvement space there are a number of initiatives across the region to improve the outcome for our patients including:
  - South Canterbury – Rapid response service
  - System flow governance group in Waitaha
  - Southern Respiratory Project – community respiratory access
  - Southern Endocrinology project – population based integrated care model

- Communications teams played a key role in the launch and roll-out of Te Whatu Ora and is the conduit to share national messaging with our local teams and various audiences. As a collective, the Te Waipounamu communications leaders continue to meet weekly to share ideas and identify where resources and campaigns can be shared. Team members have covered for each other during absences and supported each other with media responses.
- All areas are seeing vacancy pressure across services, especially Dermatology, Midwifery, Anaesthetic Technicians and Specialist Mental Health Services. Recruitment is ongoing across all areas and Te Waipounamu will be working with the National Workforce Taskforce to establish sustainable workforce alongside continuing to build our Māori and Pacifica workforce.

Te Waipounamu Region key risks

Risk area	Description	Mitigation
People	Nursing workforce shortages are impacted widely in the primary and community sector with after-hours services closing on an ongoing basis therefore causing significant pressure in ED's particularly in Canterbury.	Additional resource into Emergency Department. System flow team meeting regularly to support acute care demand across the community with sharing of resource across the system to support safe care.
Financial	RMO Winter cover rates being extended to March 2023	Capturing additional cost and Managing within exiting budget.
People	Mental Health services remain under pressure with high demands for both community teams, inpatient teams and outpatient teams.	Active recruitment continues exploring alternate workforce models and roster configuration of existing services occurring.
Financial	Planned Care delivery management	We are developing a regional proposal on the basis of funding to deliver planned care to our wider communities.
Financial	Nationally negotiated Aged Residential Care agreement	Working with local providers supporting local delivering of aged residential care services which includes but not limited to putting resource into ARC facilities if needed.

Risk area	Description	Mitigation
Financial	Ongoing costs related to COVID-19.	Waiting for the final decision around funding.
People	Emerging risk in maternity care workforce shortages in both LMC and Midwifery.	National work underway with Hospital and Specialist Services around midwifery cover over the Christmas / New Year period.

Appendix 2: Glossary

Glossary of key terms and acronyms

Term	Definition
Elective Services Patient Inflows (ESPI)	The ESPIs are a suite of indicators that monitor waiting times for elective surgery against expectations. For more information, see **Patient Flow Indicators (ESPIs) | Ministry of Health NZ**
Environmental Sustainability and Climate Resilience (ESCR)	A suite of measures to assess performance against Climate Change and Sustainability targets
Hauora	Health
Health System Indicator (HSI)	A series of measures which have been reported on as providing key insights into the performance of the hauroa sector. For more information, see **https://reports.hqsc.govt.nz/HS**
National Non-Admitted Patients Collection (NNPAC)	NNPAC provides national consistent data on non-admitted patient (outpatient and emergency department) activity. For more information, see **National Non-Admitted Patient Collection | Ministry of Health NZ**
Tangata whaikaha	People with disability
Te Aho o Te Kahu	Cancer Control Agency
Te Pae Tata	Health Plan for New Zealand, which can be found here: **Te Pae Tata Interim New Zealand Health Plan 2022 – Te Whatu Ora - Health New Zealand**

[i] In completing this report, we have sourced data from HSQC and Manatū Hauora.