# Briefing to the Incoming Minister

**23 January 2025**

## Contents

# From the Chief Executive

Congratulations on your appointment as the Minister of Health.

At Health New Zealand (Health NZ), our priority is to make sure New Zealanders have timely access to quality health care and that patients remains at the heart of what we do. We are focused on delivering the National Health Targets and Mental Health & Addiction Targets and know shorter waits will provide people with certainty that they can access the care and treatment they need. The targets also make variation in access to quality across the country more visible so we can ensure we address it. Our immediate focus is meeting the annual target milestones for 2024/25, which are based on available budget, capacity, and opportunities for improvement built into our workplans.

The Health NZ Reset aims to achieve breakeven budget by end of 2025/26. Our initiatives to get back to living within our budget for 2024/25 are showing positive signs of expenditure control based on December 2024 results. However, ongoing restraint and intensive management is required to reach our budget goal by the end June 2024/25. Labour for the public (employed) and private (funded sector) services is a significant cost driver. We have learned lessons in financial control and management from last year. Those lessons reflect the maturity level of a newly formed organisation in the foundational stages of building the processes and tools to support our performance.

Health NZ has been in existence for 2 years and 7 months following the largest organisational merger – 28 entities as well as functions of the Ministry of Health – observed in New Zealand. This merger remains in its early stages. While there is a chance to make the most of the scale and efficiency of our size to contribute to New Zealanders' health, there is much work to do to fully integrate ways of working and ensure all available resources are appropriately focused on enabling frontline delivery of care to New Zealanders.

In 2024/25, we are placing significant emphasis on changing the way we work to deliver benefits to New Zealanders by devolving more decision making and authority to regions. Establishing regional leadership roles, and shifting functions regionally, has been in progress since August 2024. We have work to do to re-engage our frontline clinical leadership in the priorities for patients and move past organisation change. We must also engage local communities and provide assurance they are able to access the care they need where it is clinically safe to provide.

While we have the lowest workforce turnover we have seen in many decades, there is still critical need in highly specialised areas that impact our target performance (e.g., oncology, intensive care, mental health). We also have work to do with you to clarify our physical and digital infrastructure investment roadmap to enable modern healthcare, including access to digital or online care and connecting information to support clinicians to provide safe care.

Of course, there is much more to the health system, including the important areas of prevention, public health protection, tailoring care to be accessible to high-need population groups and how we respond to regionally and locally specific needs. We look forward to deeper dives on these issues and other issues of importance to you as Minister of Health.

Fepulea'i Margie Apa
Chief Executive
Health New Zealand | Te Whatu Ora

# Our priorities

## National health targets

Our key focus is achieving the national health targets to deliver better health outcomes for New Zealanders and improve the performance of our health services throughout the country.

The five national health targets, to achieve by 2030, are:

1. **Faster cancer treatment:** 90% of patients to receive cancer management within 31 days of the decision to treat.
2. **Improved immunisation for children:** 95% of children fully immunised at 24 months of age.
3. **Shorter stays in emergency departments (ED):** 95% of patients to be admitted, discharged or transferred from an emergency department within six hours.
4. **Shorter wait times for first specialist assessment (FSA):** 95% of patients wait less than four months for a first specialist assessment.
5. **Shorter wait times for elective treatment:** 95% of patients wait less than four months for elective treatment.

Two of these targets – 'Shorter stays in ED' and 'Shorter wait times for elective treatment' – are All of Government targets.

To make sure we are on track in the short and medium term, each target has interim milestones for 2024/25, 2025/25 and 2026/27. These milestones reflect the capacity in funding available to be achievable, while still creating the stretch needed to reach the final target. Other measures and targets exist to ensure our services meet quality and safety standards and that there are no unintended consequences in delivering timely health care.

### *Current performance*

Below is a national snapshot of our current target performance. We will discuss with you your preferences for how, and how often, you would like to see performance data.

| | 2030 Target | 2024/25 milestone | Published Q1 performance |
|---|---|---|---|
| Faster cancer treatment | 90% | 86% | 84.6% |
| Improved immunisation | 95% | 84% | 75.7% |
| Shorter stays in ED | 95% | 74% | 67.5% |
| Shorter waits for FSA | 95% | 62% | 61.2% |
| Short waits for elective treatment | 95% | 63% | 62.5% |

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9(2)(f)(iv)

Our hospitals are delivering more care than ever before, with demand increasing at a rate greater than demographic growth, and our patients needing increasingly complex care (e.g., treatment for multiple conditions while in hospital).

9(2)(g)(i)

We publicly report our performance against each health target quarterly on our website, as well as part of our Quarterly Reports. We are scheduled to report our Quarter 2 2024/25 performance in March 2025 and will work with you and your office to prepare for this release.

### *Actions under way to achieve the targets*

Each target has an implementation plan that includes the actions that we are undertaking to achieve the targets. Health NZ's budget and resources are allocated to reflect these implementation plans.

To improve performance against the national health targets, closing the gap between demand and delivery is our priority. We are:

- increasing transparency of, and accountability for, performance
- ensuring that best practice delivery models are in place across the country
- supporting strong local, clinical leadership
- critically analysing our capacity and capability to deliver on them, and looking to alternatives (e.g., outsourcing to the private sector).

Below is some of the work we have under way, and on the horizon. Immediate actions consist of tactical and operational changes we are making immediately, while longer term actions include things we can do in other parts of the system to improve performance, such as supporting greater access to primary care and working with the Ministry of Health on regulatory barriers and settings.

Trust in vaccinations has declined nationally and internationally since COVID-19 by as much as 20%. Decline rates for vaccination has risen to 8% in New Zealand over the same period.

| Target | Key actions under way now | Next steps |
|---|---|---|
| Faster cancer treatment | Alongside PHARMAC, delivering access to new cancer medicines.<br>Establishing regional cancer networks and leadership.<br>Increasing access to stem cell transplants in Auckland and Christchurch. | Expand capacity of cancer treatment services, including in the community, to deliver new cancer medicines.<br>Pilot faecal immunochemical testing (to identify signs of bowel disease) to reduce demand for colonoscopy in 5 districts.<br>Implement LINAC replacement and expansion programme to increase access to Radiation Oncology. |
| Improved immunisation | Funding action in general practice to contact, address hesitancy, book and vaccinate overdue and soon to be due children, with PHOs providing coordination and support.<br>Established regional delivery networks to target overdue children, coordinate providers and organise outreach services<br>Increased the number of authorised vaccinators with simplified training and accreditation pathways, and the number of convenient places people can access childhood vaccination, such as community pharmacies, | Roll out immunisations by midwives and working with the College of Midwives on efficient funding mechanisms.<br>Roll out to a wider network of Plunket clinics and support pop-up events, targeting low coverage areas.<br>Improve delivery of Outreach Immunisation Service model to ensure it is accessible and effective.<br>Further simplifying vaccinator training services and complete roll out of vaccinating pharmacies. |

| Target | Key actions under way now | Next steps |
|---|---|---|
| | Plunket clinics, community events, early childhood education, and at home.<br><br>Running targeted and effective multimedia campaigns across TV, radio, social media, and trusted community advocates to encourage people to get vaccinated.<br><br>Established a fit for purpose and modern vaccine technology platform called Aotearoa Immunisation Register (AIR) to reduce administrative burden, target services and data sharing with providers. | Complete data sharing agreements for Hauora Māori and Pacific providers to enable efficient targeting and delivery of immunisation services to hesitant families.<br><br>Further enhance AIR to support coordination of delivery, enrolment, and data accuracy. |
| Shorter stays in ED | Establishing greater sense of urgency and oversight in improving actions to improve ED wait times.<br><br>Ensure patients flow through hospitals more efficiently by implementing tools such as standardised pathways of care for specific conditions to speed up diagnosis and treatment and providing real-time visibility of blockages within hospital departments.<br><br>Embedding a consistent escalation framework and early warning triggers across hospitals to ensure patient safety, prevent delays, and make best use of regional capacity (e.g., diverting ambulances to a hospital with greater capacity).<br><br>Stabilising urgent care by addressing inconsistencies in availability, funding models, and integration with other services (e.g., primary care). | Consistently discharge patients 7-days a week to free up beds to admit patients from the ED.<br><br>Establish short stay units (where they do not exist) so that patients can be moved into the unit rather than a ward.<br><br>Establish discharge lounges (where they do not exist) so that patients can wait there for transport or medicines, rather than a bed.<br><br>Set up all hospitals with an early supported discharge service that provides rehabilitation in the community (rather than hospital).<br><br>Establish datasets that identify why discharge has been delayed (e.g., waiting for aged care bed), so that blockages can be addressed. |
| Shorter waits for FSA | Working more closely with private practices and primary care to leverage capacity to undertake specialist assessment.<br><br>Implementing regional 90-day action plans, focused on stopping growth in people waiting longer than four months for both FSA.<br><br>Embedding operational controls such as booking in order of clinical priority and time spent waiting, reviewing and validating waitlists as standard practice, and ensuring clinic slots are fully utilised.<br><br>Developing new care pathways for nationally pressured services (e.g., | Increase delivery for Orthopaedics and Otorhinolaryngology (these services represent approx. 33% of the total waitlist).<br><br>Regional models of care such as regional waitlisting and consistent booking to reduce variation and improve delivery.<br><br>Deploy national standards for operational referral, waitlisting and booking management.<br><br>Use the skills of Allied Health and Nursing clinicians for FSA to release SMO capacity. |

| Target | Key actions under way now | Next steps |
|---|---|---|
| | Orthopaedics, Otorhinolaryngology, and Ophthalmology).<br><br>Deploying models of care that release capacity for additional FSAs (e.g., nurse-led clinics and virtual care). | |
| Short waits for elective treatment | Greater use of private sector to support - Outsourcing and regional panel agreements to better use private sector surgical capacity with more consistent pricing models.<br><br>Increasing use of theatre capacity with better theatre list planning, improving utilisation and efficiency, and reducing cancellations and late starts/early finishes.<br><br>Regional coordination of demand and capacity, including transferring patients between districts and insourcing of clinicians to sites where capacity is available.<br><br>Increasing the use of 'cold' elective sites (e.g., Totara Haumaru) with ring-fenced elective capacity not subject to acute demand pressures. | Regional standardisation of clinical urgency categorisation.<br><br>Regional implementation of booking in order of clinical priority and time spent waiting.<br><br>Increase ring-fenced capacity at sites such as Burwood Hospital and Counties Manukau Health Park.<br><br>Outsourcing and regional panel agreements to better use private capacity for radiology and diagnostics.<br><br>Regional coordination and service models in pressured specialties (e.g., Dermatology) and subspecialties (e.g., Spine surgery). |

## National mental health and addiction targets

We are also focused on achieving the national mental health and addiction (MHA) targets. These targets are the responsibility of the Minister for Mental Health, but visibility is important as part of the Minister of Health's responsibility for the health system. This is the first time we have had targets for this part of the sector at a national level and achieving them will require maturing the alignment between progress on operational improvements and reporting. These are reported to, and monitored by, Minister Doocey with advice from the Ministry of Health.

The five national MHA targets, to achieve by 2030, are:

1. **Faster access to specialist mental health and addiction services:** 80% of people accessing specialist MHA services are seen within three weeks.
2. **Faster access to primary MHA services:** 80% of people accessing primary MHA services through the Access and Choice programme are seen within one week.
3. **Shorter MHA-related stays in ED:** 95% of MHA-related ED presentations are admitted, discharged, or transferred from an ED within six hours.
4. **Increased MHA workforce development:** Train 500 MHA professionals each year.
5. **Strengthened focus on prevention and early intervention:** 25% of MHA is allocated towards prevention and early intervention.

## *Current performance*

Below is a national snapshot of our current target performance. Provisional Q2 data is not yet available. We will discuss with you your preferences for how, and how often, you would like to see and/or meet to discuss performance data.

| | 2030 Target | 2024/25 milestone* | Published Q1 performance |
|---|---|---|---|
| Faster access to specialist MHA services | 80% | 80% | 80.4% |
| *Faster access to specialist MHA services for under 25-year-olds* | | *72%* | *72.8%* |
| Faster access to primary MHA services | 80% | N/A | 80.8% |
| Shorter MHA-related stays in ED | 95% | 74% | 63.5% |
| MHA workforce development | 500 | 500 | 457** |
| Focus on prevention and early intervention | 25% | N/A | N/A |

*Milestones for faster access to primary services to be set once routine data collection for Access and Choice providers is established.
**Result for 2024 calendar year

Four of the targets are new, meaning data has not been previously recorded and reported to measure performance. Only the access specialist MHA services target has been previously collected. This means there is significant work required, and under way, to improve the collection, quality and consistency of the data. Current data quality and completeness means that there is a chance that performance deteriorates for some targets as quality and completeness improves.

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## *Actions under way to achieve the targets*

Each target has an implementation plan that includes the actions that we are undertaking to achieve the targets.

Delivering the faster access to specialist and primary care service targets, as well as the ED target, is led by regional MHA leads. The leads will work locally and regionally to develop and drive performance improvement plans depending on the needs of local services.

| Target | Key actions under way now | Next steps |
|---|---|---|
| Faster access to specialist MHA services | Operational improvements to Infant, Child, and Adolescent Services (ICAMHS) (e.g., referral pathways between ICAMHS and paediatric medicine for people with neurodevelopmental disorders) to improve performance for people under 25 years of age. | Disseminate successful local models and operational improvements across regions, focusing on districts and services that require dedicated support. |
| Faster access to primary MHA services | Working with providers with existing reporting capability to improve their wait time reporting and provide them access to information systems that allow them to understand their | Introduce wait times reporting for all Access and Choice providers. |

| Target | Key actions under way now | Next steps |
|---|---|---|
| | performance (wait time has not previously been reported; as of October, only 50% of providers report wait times). | |
| Shorter MHA-related stays in ED | Improving the accuracy, completeness and consistency of MHA ED data coding. | Establish efficient service delivery models between ED and MHA services, such as co-locating MHA expertise within ED.<br><br>Leverage existing ED improvements to account for MHA requirements (e.g., addressing barriers to discharge). |
| MHA workforce development | Grow the number of psychology interns.<br><br>Grow the number of new graduate nurses, social workers and occupational therapists coming into the MHA workforce.<br><br>Grow the number of psychiatry registrars. | Continue to grow the workforce groups identified, aligned to service delivery models and associated financial provisions. |
| Focus on prevention and early intervention | Analysing our investment data to understand the how we invest across different service types and measure our performance against the target. | Use the investment analysis to inform our investment and service delivery decisions, ensuring investment across the continuum of services (e.g., ensuring we continue to invest in both specialist and prevention services). |

## Health NZ Reset

In response to Health NZ's financial pressures, the Commissioner produced an eleven-point Turnaround Framework that outlines a hard-reset for Health NZ. Following feedback from the former Minister of Health and Ministry of Health, the Commissioner directed the Chief Executive to create a plan that outlines how Health NZ will operationalise the reset, guided by the Commissioner.

The latest draft of the Plan was presented to the former Minister of Health on 19 November 2024. It consists of two parts:

1) Back to Budget, including the current restructuring proposals to deliver savings.
2) The future operating model towards a consistent delivery platform that can accommodate different strategic options

The Plan is an iterative, living document that will continue to evolve. We intend to update the Plan in full once a quarter (next version due in February) and present you with a progress report, including our achievements, key risks and opportunities, and how progress against our original timeline.

### *Current Performance: Back to Budget, including the restructure process*

Health NZ is managing 9(2)(f)(iv) in revenue for 2024/25, of which 9(2)(f)(iv) is Crown Revenue split across three appropriations:

- Hospital & Specialist Services 9(2)(f)(iv).
- Primary, Community, Public and Population Health Services 9(2)(f)(iv).
- Hauora Māori 9(2)(f)(iv).

The remainder of our revenue is Pharmac funding for pharmaceuticals, contracts directly with ACC to provide planned surgery and diagnostic treatments, and contract with Whaikaha for disability support services.

Our ability to deliver the frontline health services New Zealanders expect requires us to be in a stable and sustainable financial position. Following poor financial performance in 2023/24 stemming from over-recruitment and significant one-off costs, we are working to return to a break-even position by the end of the 2025/26 financial year. To achieve this outcome, we have set budget strategy for the next three years (see Figure 1 below).

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9(2)(g)(i)

9(2)(f)(iv)

## Financial results to December 2024

Our December results (see table and graphs below) show monthly expenditure decreasing over the first two quarters, getting closer to matching revenue. Updates to the full year forecast will be considered by the Commissioners' Finance, and Risk Assurance Committee in early February.

Savings and cost-out work programmes are in place and have been designed to not impact the quality of services or delivering our national health target milestones. Careful monitoring of delivering savings, while not taking on unexpected cost pressures, is key to achieving an overall net recovery.

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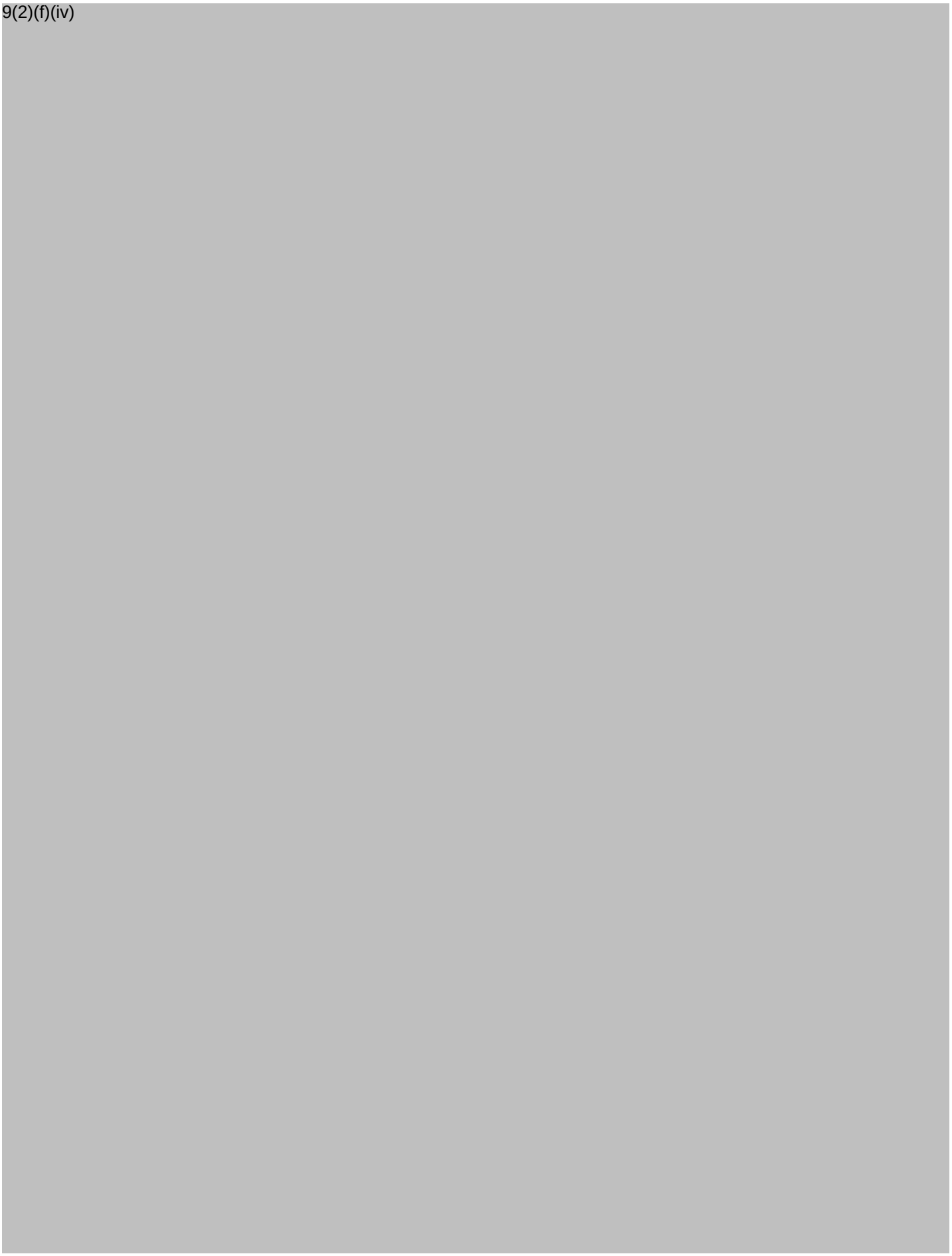

## Reset of Health NZ and consultation processes

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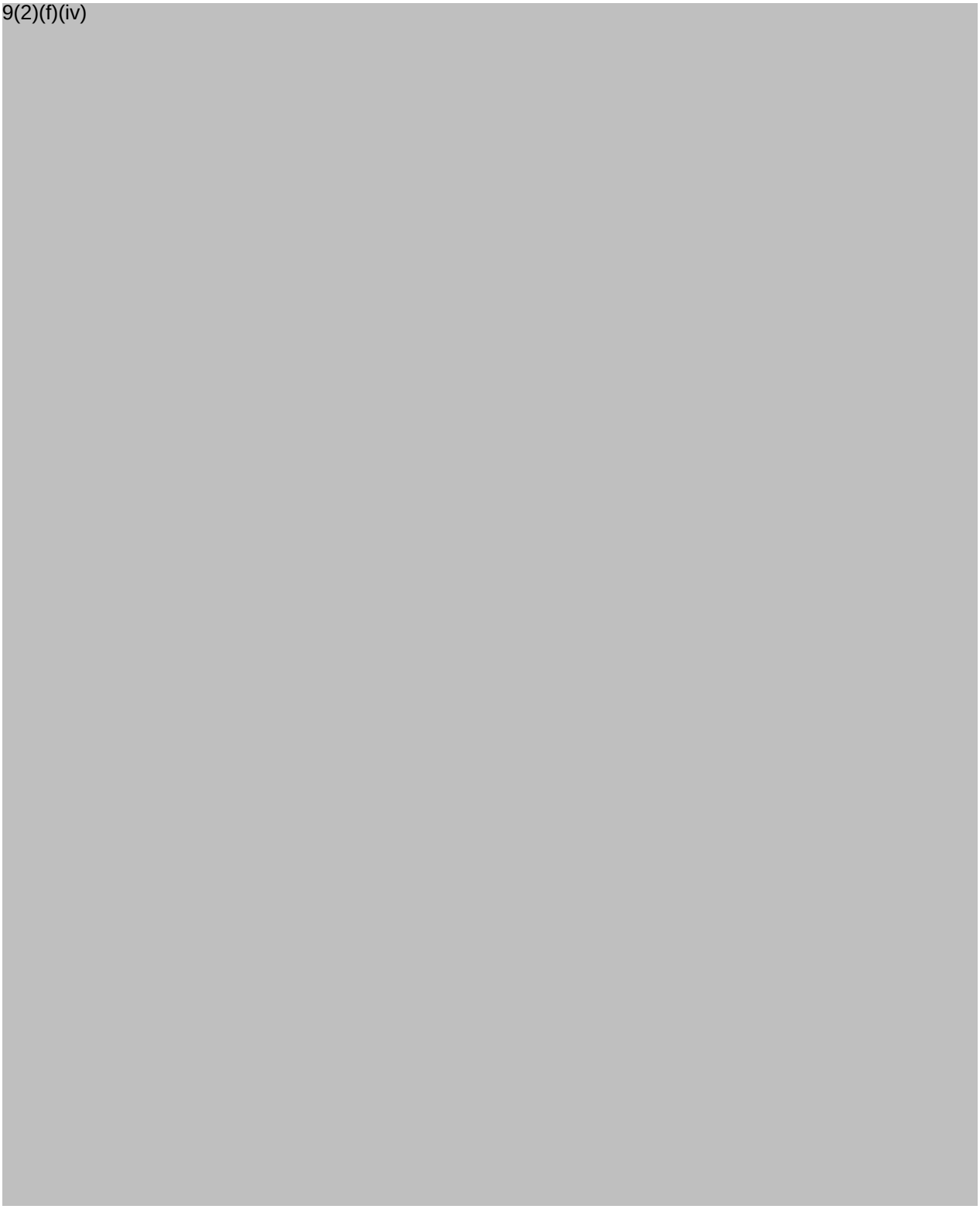


### *Current Performance: Performance Model "New Ways of Working"*

Following our structure processes, the next stages of our reset include ensure our functions are aligned to our new ways of working, support devolution and achieving key priorities. The purpose of resetting Health NZ's performance model, or ways of working, is to set up a devolved and clinically led organisation that delivers quality, compassionate and affordable health care at the right time, in the right place.

To date (over the last six months) we have:

- Designed, and started implementing, the foundational layers of the ways of working.
- Targeted interventions and leadership/culture support to poorer performing campuses (e.g., 9(2)(f)(iv) ).
- Established a more regionalised leadership model and devolved accountabilities and decision making to be closer to the patient.
- Our ELT has been reset and restructured, and business unit restructuring is under way.
- Concurrently, service volume continues to grow and progress on national health targets is under way.

9(2)(f)(iv)

# Working with Health NZ

## How we deliver health services

Health NZ leads the day-to-day running of the public health system, with our trusted and skilled workforce providing high-quality health services to New Zealanders. We deliver many of these services directly (e.g., hospital services), and we partner with providers by purchasing and funding other services (e.g., primary care).

Operating and improving the health system depends on close relationships with all our stakeholders, including consumer groups, professional bodies, unions, non-government organisations, Primary Health Organisations, and private companies.

Our guiding legislation, Pae Ora (Healthy Futures) Act 2022 sets us three objectives:

- Design, arrange, and deliver services to achieve the purpose of the Pae Ora Act in accordance with the health sector principles.
- Encourage, support, and maintain community participation in health improvement and service planning.
- Promote health and prevent, reduce, and delay ill-health, including by collaborating with other agencies, organisations, and individuals to address the determinants of health.

**Delivery:** Health NZ operates across four regions (Northern, Te Manawa Taki, Central, and Te Waipounamu), with each region consisting of multiple districts (see map on following page). We deliver hospital, and purchased and funded, services regionally, while public Health and Hauora Māori Services are led nationally in collaboration with regional teams.

**Clinical:** The Chief Clinical Officer leads a national team focused on clinical leadership and clinical networks to establish national standards, clinical priorities, and advise on unwarranted variation in access to services and health outcomes across the country.

**Corporate:** Frontline delivery is supported by national corporate functions, including finance, human resources, physical and digital infrastructure and investment, legal, and government services.

**Planning & Analysis:** The national Planning, Funding and Outcomes group also supports regions to design, deliver and commission services, and is responsible for monitoring and analysing our performance.

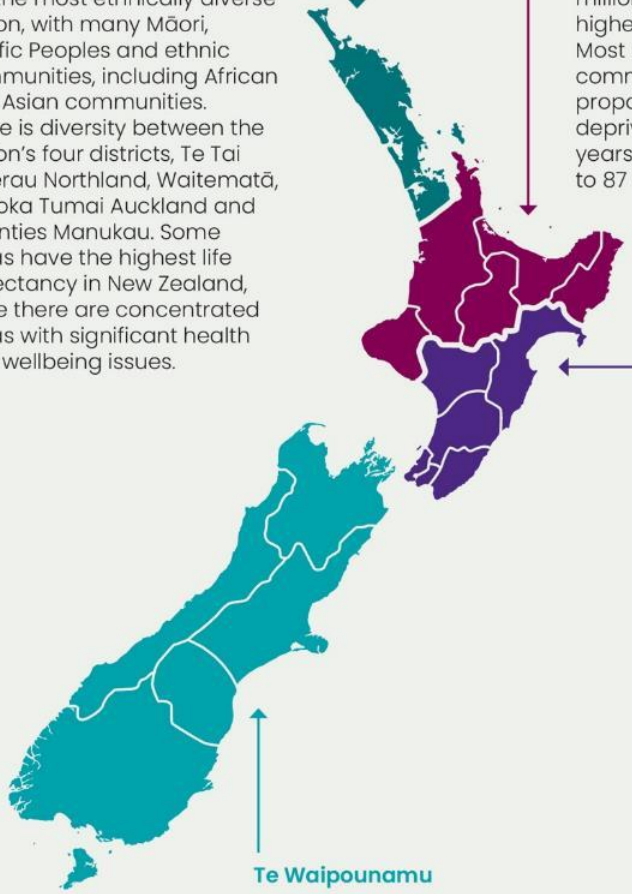
# Health New Zealand regions

### Northern region

The Northern region has the largest and fastest growing population of the four regions, with nearly two million people. It includes our largest city, and a significant rural population. It is the most ethnically diverse region, with many Māori, Pacific Peoples and ethnic communities, including African and Asian communities. There is diversity between the region's four districts, Te Tai Tokerau Northland, Waitematā, Te Toka Tumai Auckland and Counties Manukau. Some areas have the highest life expectancy in New Zealand, while there are concentrated areas with significant health and wellbeing issues.

### Te Manawa Taki

Te Manawa Taki means 'The Heartbeat' and is the name gifted to represent the five districts: Waikato, Bay of Plenty, Taranaki, Tairāwhiti and Lakes. The name in the context of the combined region represents "Always ready to go". It has a population of over one million people – 20% of New Zealand, and the highest proportion of Māori of all the regions. Most Māori and Pacific Peoples live in urban communities and the region has the highest proportion of people living in areas of high deprivation. Life expectancy ranges from 74 years of age in one of the most deprived areas, to 87 years of age in the one of the least.



### Central region | Ikaroa

Approximately one million people live in the Central | Ikaroa region. The region covers five districts: Whanganui, Capital, Coast and Hutt Valley, Hawke's Bay, MidCentral and Wairarapa. More than 20 iwi hold mana whenua over the region. Five Iwi Māori Partnership Boards play a vital role in ensuring the voice of iwi, whānau and hapū informs the shape and delivery of health and wellbeing services. There is a lot of innovation occurring throughout this region.

### Te Waipounamu

The name Te Waipounamu literally means 'Water and Greenstone', as this is the only place that pounamu is found in New Zealand. Te Waipounamu is geographically the largest and most sparsely populated region, covering the districts of Nelson Marlborough, West Coast, Canterbury, South Canterbury and Southern. The regional team works in partnership with Iwi Māori Partnership Boards, Te Tauraki, Te Kāhui Hauora o Te Tau Ihu, and the emerging board for Wharekauri | Rēkohu, and engages widely to understand the needs and aspirations of the people in this region.

## Our hospital system

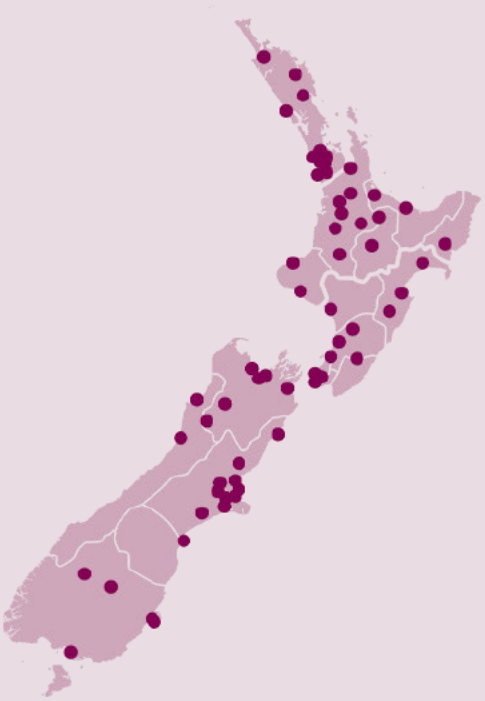
### Public Hospitals

Health NZ owns 86 sites with nearly 11,000 beds or bed spaces. These range from small health care clinics and sub-acute units, through to secondary and tertiary hospitals. Most health clinics offer primary and community health services. They may have inpatient beds for continuing hospital care or low-risk births and transfer emergency or complex patients to a secondary or tertiary hospital. We often partner with community organisations to deliver care in these clinics. Sub-acute units provide day surgery, lower-level diagnostics, day stay care, some inpatient surgery and some clinical support services.

Secondary hospitals cater for most of the local population's health needs, offering 24-hour acute services and intensive care, planned surgery and care across a range of subspecialties. Our tertiary hospitals provide the greatest range of subspecialties and are staffed with 'on-site' rather than 'on-call' specialists. Across our sites over 60 service subspecialties are offered.

Primary care facilities are spread throughout New Zealand. These consist of GP practices, pharmacies and accident and emergency centres.

### Locations in New Zealand



| Regions | Total number of beds* |
|---|---|
| Northern | 4,209 |
| Te Manawa Taki | 2,708 |
| Central \| Ikaroa | 1,749 |
| Te Waipounamu | 2,079 |

*This reflects total beds/bed space Health NZ is certified to provide. It represents all types of hospital beds (ICU, neonatal, adult medical, etc). The number is the total physical spaces, not resourced/non resourced beds.

## Our funded and purchased services

### Funded providers

Health NZ has partnerships with a range of providers:

- Aged residential care
- Allied health providers
- Ambulance non-government organisations (NGOs)
- Community health and social providers
- Hauora Māori services
- Home based support
- General Practices and Primary Health Organisations (PHOs)
- Laboratories and radiology facilities
- Mobile services (i.e. screening and immunisations)
- National health NGOs
- Pacific health services
- Pharmacies
- Primary maternity services
- Private hospitals
- Urgent care clinics

## Roles and responsibilities

We are a Crown agent under the Crown Entities Act 2004. Our Commissioner (and Board, when in place) is responsible for the governance of the entity and accountable to you for performing his duties.

### *Your key strategic and accountability mechanisms*

As a matter of priority, the Ministry of Health will work with you to develop your **Letter of Expectations** (LoE) to us. Your LoE will be key to our next **Statement of Performance Expectations (SPE)** for 2025/26. A draft SPE must be submitted to you in early April and finalised by June 2025.

Our current **Statement of Intent 2024-2028** (SOI) and **Statement of Performance Expectations 2024/25** were tabled in December 2024. You can require us to produce a new SOI at any time.

The **New Zealand Health Plan (NZHP)** sets out how we give effect to the Government Policy Statement on Health (GPS). The Pae Ora Act requires you to approve this plan, 9(2)(f)(iv) . The NZHP must take effect from 1 July 2024.

These statutory accountability documents, along with budget decisions via Vote Health, are your key levers to set the strategic direction and priorities for us, alongside our regular interactions with you through our Commissioner, Chief Executive and executive leaders.

### *Responsibilities of the Commissioner*

In July 2024, Professor Lester Levy was appointed as Commissioner, replacing the Health NZ Board. He has been appointed for a 12-month term. Commissioner Levy has appointed three Deputy Commissioners – Kylie Clegg, Roger Jarrold, and Ken Whelan – to support him.

The Commissioner (or Board, when in place) is responsible for the governance of the entity and accountable to you for performing his duties. Decisions relating to our operations must be made by, or under the authority of, the Commissioner (or Board).

### *Responsibilities of the Chief Executive and Executive Leadership Team*

Responsibility of day-to-day management and leadership is delegated to the Chief Executive, Fepulea'i Margie Apa. The Chief Executive is accountable to the Commissioner (or Board, when in place). An overview of the Executive Leadership Team is included in the Appendix.

# Items that we'd like to engage early with you on

You have indicated topics where you would like to undertake in deep dives. We will work with the Ministry of Health to support these discussions.

The table below lists additional key matters we need to engage you on soon, subject to changes and additions based on our early discussions with you.

| Focus | Description | Timeframe | Briefing No. |
|---|---|---|---|
| Infrastructure - New Dunedin Hospital (NDH) | Update to Joint Ministers' ahead of meeting (28 January) on progressing the two options presented in December | 24 January | HNZ00076573 |
| Infrastructure - Hillmorton Hospital - Adult Acute Facility (AAF) | Approval for funding – Tender expires 7 February and costs will increase if funding not approved before expiry date | 28 January | HNZ00074227 |
| Targets - private partnerships strategic approach | Briefing outlining options to progress private provision of services to support meeting planned care National Health Targets | 28 January | *TBC* |
| Infrastructure - Hawke's Bay Inpatient Unit Single Stage Business Case (IPU) | Business Case approval - Hospital is at capacity and approval for use of funding to this temporary facility is urgently required to relieve the pressure. | 13 February | HNZ00072894 |
| 9(2)(f)(iv) | | | |
| Infrastructure - Auckland Hot Water Reticulation (FIRP Contingency) | Equipment is failing and approval is urgently required to use available funding from FIRP contingency. | 13 February | HNZ00076400 |
| 9(2)(f)(iv) | | | |

| Focus | Description | Timeframe | Briefing No. |
|---|---|---|---|
| 9(2)(f)(iv) | | | |

# Health New Zealand Executive Leadership Team

***Note:***

- *Advisory roles to the Chief Executive include the Head of Communications and Government Services; Chief Legal Officer; Chief of Audit and Assurance (reports to Chair Finance, Risk and Audit Committee)*

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**Margie Apa**
Chief Executive

**Mark Shepard**
Regional Deputy CE, Northern

**Cath Cronin**
Regional Deputy CE Midland | Te Manawa Taki

**Robyn Shearer**
Regional Deputy CE, Central | Ikaroa

**Martin Keogh**
Regional Deputy CE, South Island | Te Waipounamu

**Dr Dale Bramley**
National Director, Planning, Funding and Outcomes

**Dr. Richard Sullivan**
Chief Clinical Officer

**Nick Chamberlain**
National Director, National Public Health Service

**Selah Hart**
Interim National Director, Hauora Māori Services

**Richard Aldous**
**(Bevan McKenzie from 28 April)**
Interim Chief Financial Officer

**Fiona McCarthy**
Interim Chief People Officer

**Jeremy Holman**
Chief Infrastructure & Investment Officer