**24 March session: Te Puea Winiata and Pauline Fakalata | Mylee Gordon**

Tēnā koutou, tēnā koutou, tēnā koutou katoa.

Ngā mihi maioha ki a koutou katoa. Nau mai, haere mai, haere mai, tēnā tatou katoa. Nō reira, he karakia tīmatanga.

E te huinga

Whāia te mātauranga, kia mārama

Unuhia te anipā,

te nguha, kia mahea

Kia whaitake ngā mahi katoa

Tū māia, tū kaha

Aroha atu, aroha mai

Tātou i a tātou katoa

Hui e, tāiki e.

Tēnā koutou katoa

Tuarua, ki ngā mate, haere, haere, haere moe mai rā

E te hunga ora o te ao ora

Tēnā koutou katoa

Tuatoru, ka mihi ki te iwi kāinga

Ki a Muaupoko, ki a Ngāti Raukawa ki te Tonga

Tēnā koutou katoa

Nō reira e te whānau

Tēnā koutou, tēnā koutou, tēnā tātou katoa

Welcome, everyone, to the Quality Improvement Scientific Symposium. Ko Jane Cullen tōku ingoa, lead advisor, Quality Improvement here at the Health Quality & Safety Commission. I'll just hand over to Gillian Bohm to say a few words before we start.

Thank you very much, Jane, and thank you for doing the karakia. It's a great start to the way we want to continue during the session. I just want to give everyone the warmest of welcome from all of us at the Commission. We know that, currently, the life out there and delivering health services is very busy and sometimes quite stressful. So, we hope that you enjoy some of our calming music and that you enjoy taking a little break away from that busy clinical interface and join us today.

I also want to welcome you on behalf of our chief executive, Dr. Janice Wilson, who was absolutely delighted when she looked at the list of people who've enrolled for today. So, a very warm welcome from her. And apologies that she can't be with us today doing that.

You've read all the instructions. And, please, do ask us questions; put those in the chat box. One of our mottos that we have in doing this is that, given the diversity of people that are here and the expertise that many of you have, and it is a system where we believe everyone has something to teach us and we all have something to learn. So, it's a session where we should have all teach, all learn. Thank you very much for coming. Over to you, Jane, to introduce the speaker.

Thank you, Gillian. And I just want to remind everyone that this session is being recorded. Tēnā koe Te Puea. Te Puea Winiata, who is our keynote speaker today, has worked in the health and Māori mental health and addiction sectors in social services for many years. She is the CEO of Turuki Health Care, which is a health and social service provider in South Auckland. Chair of Te Rau Ora, board member of Huria Management Trust in Tauranga Moana and co-chair of the Ministry of Health's COVID-19 Implementation Advisory Group and other Māori health advisory groups. So, we're very fortunate to have Te Puea with us today and look forward to hearing your presentation, Te Puea. Thank you.

Tēnā koe Jane, mō tō mihimihi, mō tō karakia i tēnei ahiahi, tēnā koe

Kia ora koutou katoa

Ko Takitimu te waka

Ko Mauao te maunga

Ko Ngāti Ranginui, ko Ngāi Te Rangi ōku iwi

Nō Tauranga Moana ahau

Ko Te Puea Winiata taku ingoa

I'm sorry, Jane, I should have updated my bio with you, but anyway, if people accept that, that was probably last year. And I know that there have been some delays. So, apologies for that. But anyway, I thought that I'd just start today with a little story. And that is, when I go to one of the clinics in Māngere, we're across the road from WINZ. And the last couple of days, I've seen a line of people that stand outside WINZ, in all sorts of weather. But the challenge for a lot of our whānau is the fact that it is really difficult – difficult times, and that the issue of dignity in this time for whānau is huge. And one of the great things that we're able to do through our networks is to raise some of those issues. But I did want to acknowledge, as we gather here today, some of the challenges, big challenges, that whānau are facing during this time.

Today is about improving equity for us as a kaupapa Māori organisation. It means constant adapting, constant recognition of where things aren't working well, where there are issues of inequity that need to be exposed and addressed. And sometimes, it is about going in to battle and finding systems that are going to work better for whānau.

What I'm going to do is just to take you through today some of the adaptations that we've had to make as an organisation, addressing the issues around equity and actually reaching whānau in a better way, given the kind of context that we're working in today.

So, the title of my presentation today is Move Fast but Slowly, and that – some of the tension in the context that we're working. And just to jump in there, one of the issues that we often face as an organisation is that people often think that we're just a health organisation because of our name, but over many years, we've been able to develop a range of social services to complement what we do in the health space.

And of course, if you have a look at the needs of whānau coming forward, it's never with one issue. And so – that we're involved in employment, housing. We have a significant team that do school-based health, but also wrap-around social services and that – we're also a national call centre for Oranga Tamariki. We're in the Whānau Ora space and the justice space. We do a lot, in terms of 0 to 5 services. Next slide.

We're also a larger organisation. I guess, for many people, primary health care means … might conjure up smaller GP services, but because we're an integrated service organisation, we now have over 220 staff – and most of our staff are Pacific and Māori. We have a range of languages and, really, they reflect the communities in which we serve. Next slide.

But we can't do it alone, and I want to emphasise the importance of working with the networks of other providers and organisations that enable the work to be done. And also that there's a growing sense of the new health reforms. And at this time last year, we caused a bit of a ruckus because, actually, we saw that the borders were also around iwi rohe not just DHB rohe. And so, we moved into supporting vaccinations across the DHB lines. And I think that it's really important that we are continuing to grow those natural relationships and groupings that are important to whānau, hapū, and iwi. And what we do, of course, would be a lot harder if we couldn't actually do it with others. Next slide.

We are in constant adaptation, looking at different services, and I'll talk to some of these today. But certainly in the primary health care arena and our wellbeing services, we've been proponents of low carb, healthy fat, in terms of addressing diabetes. We've worked in the justice space, and I think we've been really encouraged by the response that we've had with the building of mobile services during the COVID pandemic, which is something that we're definitely going to be carrying forward into what we hope will be a post-COVID era. Next slide.

So it is, for us, taking services closer to the people. Gone are the days that we can sit there and expect people to come to the clinic. This is not because people won't and don't want to come to the clinic, but in terms of keeping people safe and acknowledging the different needs of people, and improving access, that mobile services will be increasingly important. Next slide.

I just wanted to celebrate that this time of the month is our first anniversary of doing our first COVID vaccination mobile service, which happened out at Pukaki. And it was so new that there wasn't a lot of support for it because there were no standing operating procedures – standard operating procedures for doing COVID vaccinations in a mobile kind of context.

But thank goodness that these wonderful people from Waitematā Health and Rawiri Jansen supported our move in this area and came out on the day of our first mobile vaccination event to come and accredit us. But it was the day that we signalled that camper vans and traffic cones and fold-up tables, et cetera, et cetera, were going to become part of our standard equipment, in terms of our services. Next slide.

And the reason why we felt unable to do this was because we'd already done over 300 vaccinations in our MIQ run, when the vaccination was first released, and we've done heaps of mobile vaccinations for flu and with testing and had also been delivering mobile primary health care services in the previous year. And what I really want to say to – and encourage people is, it's not what you can't do, but really what you can do. And this is going to be really important moving forward, in terms of how we adapt to reach the people. Next slide.

I wanted to talk about smoking cessation as one of the adaptations that we've made, and I really want to pay homage to Whāea Hera, who is our smoking cessation practitioner. Next slide.

For a number of years, we had a contract to deliver a four-week programme, and that programme suits a lot of people, but what we were finding that it wasn't connecting Māori woman into that programme, and we've done quite a bit of work with MOH to evolve services for Māori women. But today, where we've got to is developing a group of Māori women who want to give up smoking and can come and weave korowai. So, while they're weaving korowai, they are also sharing story. And, through that story, are creating a beautiful taonga. And that taonga becomes representative of the healing journey that they've been on. And I want to pay homage to Whāea Hera because, at 70 years old – I hope she won't mind me saying that, but she runs every day, 10Ks; she does some fitness programmes online for us; but she's had to adapt to working within face-to-face groups; she's had to learn how to set up a camera, lighting, sound and go online so that these groups can continue. And I have to say that there are some really powerful stories of love and acceptance, engaging with Māori women through weaving korowai.

And the other thing is that the women who come to that particular group can also access a range of other health and social services through Turuki. Next slide.

The Low Carb Healthy Fat Programme has been an adaptation that we've made to address some of the issues that we had in trying to reach in and lean into the issues of whānau, who, we felt we were doing all of the right things, but we weren't making a difference. Next slide.

And it started, actually, with one of our patients who was being managed by Lily Fraser – Dr Lily Fraser. She realised that, with Joseph, things weren’t working out. And he hadn't been to the clinic for a while, and so she decided to do a home visit. And what she did was find out and see more of the context of his situation. And I won't go in to describe that in any detail, but what she found was that the eating regime that we had him on just wasn't suited to either the circumstances that he was living in, with eight children, sole parenting, and also to his tastes. So out of that, Lily did quite a bit of research around low carb, healthy fat. And as a result, Joseph lost a huge amount of weight but also zeroed out his diabetes. And since then, the programme has continued to evolve with one-to-one support for whānau. We … Every so often, we do what is called the eight-week challenge, which is an eating and exercise regime. It becomes – us Māori are very competitive in that space. We've also developed a Healthie app. We do an online cooking and shopping programme for whānau, and we've built the programme around kai that whānau like to eat. So, we are often sort of competing with the nutrition pyramid of the Ministry of Health, but this is what we've found to work for our whānau, or for many of our whānau. And currently, we're presenting and participating in a long-terms condition research project called Te Ranga Ora with Counties Manukau. Next slide.

Of course, the COVID response has provided us with the opportunity to be involved in a range of services, so we're right across testing, vaccinating, home isolation services, which we call Noho Tapu. Through our networks, we've become a distribution hub for RATs testing, directly with the Ministry of Health, and as I said before, doing mobile primary health care. Next slide.

I also like to talk about some of the collaboration and learning that we've had from others doing things differently. And I wanted to acknowledge the Ira Dot Campaign. It was decided amongst Māori providers that we needed to change the languaging of vaccinations when we started the 12 to 18-year-old vaccination roll-out, and so we started to talk about ‘Getting your dot’, ‘Dot your lot’. And this campaign was driven by Ngāti Whātua and our Taumata Kōrero Māori provider network, and this was taken at Kia Aroha College, sorry. In the school hall, this is when we were setting up, we live streamed; we connected a whole lot of Māori providers together to connect around the roll-out. And one of the things, on the left-hand side, that picture of the booths – we decided that we'd do a whānau approach; we'd have whānau sitting up on the bleachers when their rangatahi were getting vaccinated, and that was kind of cool: whānau could ask questions about the process around the COVID vaccination, and a number of them were jumping in and out of the chair themselves to get vaccinated.

And sometimes, you know, the opportunity to do things differently, depending on the cohort that you're working with, is really awesome, and to be doing that with other Māori providers. Next slide.

Noho Tapu, so, our home isolation services for whānau. Next slide.

We had some big challenges setting up services in this arena. We were setting up new services without contracting arrangements in place; we just had to go. We had no sense of size and scale. When people talked to us about Omicron, it was everything was size big; you just have to prepare for size big. How did we think about the number of staff that we'd need and the kind of services that we would need to be able to respond?

And we really had to push out the waka in open waters before we actually had built it properly, and that's always a challenge. We did that by thinking across our organisation. What were the pieces of experience that we already had? And so, we created a bit of a bitser model from past experience and what we were predicting whānau might need. We also had to think about data collection. The worst thing about setting up these kind of new stand-up services is people not knowing what data to collect, and then three months down the road, funders are saying ‘So, we were thinking the other day about x, y, and z, so, can you tell us how many you did of that and what the impact was and blah blah blah? Well, it would have been great information to get from the beginning. But he aha, that's one of the challenges.

We also had to set up new financial systems, repurpose our facility, set up communication systems and partnerships with key stakeholders that were going to help. We had to reassign and redeploy staff, re-roster staff and think about what a surge workforce would look like as the Omicron pandemic increased. And also, in the midst of all of this, particularly this month of March, we were also ensuring that we were managing the wellbeing of our staff, particularly as staff were contracting COVID themselves. Next slide.

And so, our model for a home isolation, of course, includes referral, triage and assessment pathway. It's very much a Whānau Ora approach. Whānau can access all or part of our service. We've had to set up some call centre hubs for our clinical and welfare services. We've had to reassign staff to ensure that we could offer a seven-day-a-week service and set up a different arrangement for back office and logistics, specifically bespoke for home isolation services. Next slide.

And so, this is basically what it looks like. We have a call centre, so when whānau have tested positive, they can call in. Most of the people that we're dealing with at the moment are our own patients. We have nearly 15,000 enrolled population, and so, a lot of them are actually people that we're actually contacting because we see their test results or we've seen their test results or are whānau that are ringing up for help. So, people can access our health monitoring system: that's covered off by nurses, doctors and our health care assistants. We've also got an MSD contract to provide welfare services for whānau that don't quite meet that threshold for WINZ but nevertheless, are really challenged to be staying at home and not working. And so, we’ve – over the last six weeks, we've put out around $60,000 worth of support to whānau. We also had to set up a kai delivery service; we had to train new staff around safety, around contactless deliveries and also set up packing area for kai. And we're getting kai through Taumata Korero and also being supported by Whānau Ora in that space. And also set up a logistics day, I mean, we haven't worked for the Defence force or any transport company, and so that's been a significant part of our learning as well. Next slide.

The other interesting thing is that we have been approached by funders, government agencies, to umbrella other partners with funding arrangements, and this is a new approach to support some of the smaller providers to participate in the work in their community. Because, probably, in this space, they're doing a lot for free but actually should be paid. And so, we've enjoyed some new relationships in this space and a new way of working. And where we can support the distribution of resources out to those community organisations, they've also helped by managing the logistics and deliveries of their own enrolled populations, so, it kind of works all together really well. Next slide.

So, really, COVID, of course, has changed us forever, and we'll never fit back into the box. We are really focused now on thinking about how we get more services out to people, recognising those communities who remain underserviced and offering partnering arrangements. We're accessing more people in the home, and I see something that's come up in the chat. Yes, we've gone totally virtual around our wellbeing services, so there are programmes on our Facebook page. And ramped up our wairua services significantly, especially during our lockdowns. And a big thing here is, because of all of the constant changes of the policy settings, we're always trying to find ways of getting reliable information out to whānau to help keep them up to date. Next slide.

And so, … this is my last slide … during this time, it's been really crazy, but it's been quite liberating for Māori providers to be able to respond in the way in which we've been encouraged to respond and funded to respond, but we do have to work at breakneck speed and react to constant changes and policy settings. And this adjustment impacts on staff capacity, facilities, repositioning our resources, comms with staff, comms with whānau, financial systems, et cetera, et cetera. And all this, while we acknowledge that a lot of our staff are sick and under pressure at home, dealing with their own whānau, and still being able to log on and support the mahi.

We've also had to be focused on unblocking areas where there are blatant inequities and smooth systems that are obviously not working for whānau. And some of our contracts reflect a pre-COVID context. In other words, they were set up when we weren't having restrictions on our movements or trying to contain a pandemic, and so, it's been really challenging meeting compliance on some of those contracts and also doing the reporting. So, in this space, we're managing COVID-related services, our business as usual and also preparing to enter into the new health reforms and figure out where our organisations are fit.

But there are pivotal points along the way that I want to flag, that it's not all busting a gut all of the time. There are times where we just have to slow down, make sure that we're all on the waka, we haven't left anyone behind, that there aren't any holes in the waka that we haven't seen and also watch for gaps. But, at the same time, we need to maintain the pace of the context in which we're working in. So, a colleague the other day remarked to me, it's just like going fast … but slowly, and there is this tension around keeping up the pace, responding and managing all of the things that we need to manage but also having those periods of reflection. It would be really nice that we could say to staff, ‘OK, we're shutting down the organisation for a week. Let's go and have a bit of a break and a bit of a reflection’, and then think about what we want to do when we come back. Not possible, but it is exhilarating, and we are excited to be able to deliver the services that we're able to deliver and be in this constant learning space with whānau, with our stakeholders and with other providers. So kia ora.

Kia ora Te Puea. Thank you. It was fantastic and very inspirational, as you can probably see by some of the comments coming through in the chat. There have been a couple of questions come through, which I'll just read out. So, the first one from Mary [Sedden]. Thank you. Nuku is all about relationships and trust, and you embody this. My question is, how do you see the locality prototypes working for you? Not an easy question for you.

[Laughter]

Well, we'd like to know. I think there are so many missing bits to the picture for us, and some of it is being driven centrally, and some of it is being driven by the DHB. So, we're having to connect with a transitioning unit. But what we hope will happen is that Māori providers will take the lead in some of the locality space and that we'll be partnering up. But yeah, if you've got any information on this, we'd love to know.

[Laughter]

Thank you. So from Fiona Miles, how do you see your service will integrate with the new Māori Health Authority? What is your vision of what you are hoping for?

Well, what we've been told is that all of our contracts from DHB and MOH will go over to the Māori Health Authority. And where we've started to get some gains around commissioning, around working across borders, not being confined, we can think about other borders and spaces to be working in, that that actually will become the norm. And we're really hoping that this will be a far more – I have to say, efficient, in the terms of not putting stuff, resources into places where we're just checking a box, but actually pooling our resources into one place to be far more effective. And the challenge for us is that we're probably managing at the moment about 48 contracts. Wouldn't it be great if I had a one-pager where we had an agreement with the Māori Health Authority to say, these are the outcomes that we want to achieve in South Auckland and in our other areas of need across our region in Tamaki, and are you OK with this? Is there anything else that you'd like to be putting on this bit of paper? But we're taking all of this money, and we're going to go out and do what we need to do and what we've got the capacity to do, and then we'll tell you a story about how that's going. That would be my dream for the Māori Health Authority.

Great. So, you've spoken about a few of the challenges that you encountered on the way. I wonder if you can tell us about some of the challenges with rolling out the vaccinations to 5- to 11-year-olds.

Yeah. Unfortunately – and this was no one's fault, but when we got wind of the 5 to 11s, it came at the end of last year. And it was not going to be released until, I think, the 17th of January was the first date. So, schools were going, were breaking into the holiday period, but also a number of the schools had to close at that stage because of the COVID, children getting COVID. So, we were kind of left, as health providers, a little bit on our own because we couldn't engage with schools. And even when schools came back, there were some concerns, really, about the anti-vax campaigns on school grounds, trustees not feeling confident about this vaccination programme at that time. And there were a whole lot of roll-out issues. So, we knew that we had to go to events-based vaccination, providing access through events. But also, we had enjoyed a period of time where we were able to use our HCAs to become vaccinators, and now we were reduced in our workforce with just having nurses being able to vaccinate children of that age. So, our focus was really about thinking, let's do this vaccination roll-out and look at how we support schools to get children back into school safely.

What we're seeing now is, there's definitely been a fall off. Because people are wanting to be tested, there's been a fall off of vaccinations, but also that we're working with the Ministry of Education through our networks and other Māori providers to think about how we get tamariki back and staying in school, and what are some of the challenges now, reflectively, looking at a period where there has been a lot of transmission of Omicron through children at schools, coming back to their whānau?

And so, a lot of families have either not returned their children to school or have and then are keeping them at home, and there are a lot of children, tamariki, that are lost altogether. So we're having to think of our whole range of different strategies to engage tamariki back into education, whatever that might look like, but also to wrap around some health strategies for them and their whānau as well at the same time.

Thanks Te Puea. Also, I was wondering – you spoke about the importance of the … working with networks of other providers. Can you give us any tips about developing those relationships and networks with other providers?

Well, some of them have evolved because … for us because we've seen particular communities where they've tried to set up small services to those communities but haven't been able to access information and resources, and so we've developed a relationship that is built on, what are the priorities for them? But a lot of the Māori provider networks have been established because of long-standing relationships in a variety of other contexts; and some of those are iwi based, some of them are South Auckland based, some of them are because I know somebody or somebody knows me, and you're able to leverage off those relationships.

We've had to leverage up relationships very quickly that become high-trust relationships. And those need considerable work, so I do spend a huge amount of work on Zooms during the day just keep all of those plates spinning.

Thank you very much, Te Puea. I'll hand back over to Gillian for the next section, but there are some lovely comments for you in the chat. So hopefully you can go in there and read the chat and thank you very much.

Kia ora.

Kia ora.

Also, my thanks. Very inspiring and great to see, from the actual practical side, some of the things that you had to do that continued to look after the population that you serve.

So, onto the next presentation for this afternoon, and the next presentation is about improving equity for Māori and Pacific people on the Planned Care Pathway at Auckland DHB. We're very, very lucky to have Pauline Fakalata and Mylee Gordon to do this for us. There they are, spotlighted hopefully.

And Pauline and Mylee, I wonder if you could start by telling us a little bit about your roles and how that works within the DHB. Thank you.

Ko Tapuwae o Uenuku tōku maunga

Ko Wairau tōku awa

Ko Kurahaupō tōku waka

Ko Wairau tōku marae

Ko Mylee tōku ingoa

Kia ora, my name's Mylee, and I'm the team lead for the Kaiarahi Nahi team here at Auckland Hospital. And this is Pauline.

Malo e lelei, everyone. I'm Pauline Fakalata. I'm the team lead for our Pacific Planned Care and Education team at ADHB.

And I just want to mihi to Te Puea for your lovely presentation and work that you're doing at the moment. I'm just going to share our screen.

OK.

So, we're involved in an equity project for the ADHB to improve outcomes for Māori and Pacific patients, and we quite like this definition of equity from the Ministry of Health in 2018. We all know that inequities lead to poorer health outcomes and life expectancy; life expectancies, stigmatisation, things like that, so yeah.

So, just a bit of background, in 2019, it was highly likely that the DHB was not going to meet their targets for planned care services, which included patients not being seen within 120 days for their first specialist appointment or having their surgery completed within 120 days after being put on the waitlist. Then in 2020, COVID came along, and that drastically reduced our abilities to do planned care.

So, the problem that we found, or that the ADHB found, was there were inequities that existed. Our people were being asked to attend more follow-up appointments before being waitlisted for surgery; we were waiting longer, and therefore, more likely to receive surgery acutely; and we were more likely to have our surgery clinic cancelled on the day, or more likely, not to attend the surgery. So, our project was set up to address this problem, and the aims of the project were to identify and mitigate avoidable, unjust or unnecessary barriers and system issues. We wanted to improve the measurement of inequalities at the DHB, and we, importantly, wanted to improve the patient experience and the confidence in the health care system.

So, a rapid response – Yeah, two rapid response teams were set up: the Māori team and the Pacific team. And our Māori team is made up of – we're all Māori, have a Māori background, so there's 10 of us in our team. And Pauline's team has 10 Pacific nurses, and they have a fluency in a Pacific language. And this is to ensure that there is cultural intelligence alongside our clinical work that we do. So, our two teams were set up with support from the performance improvement team, and our focus was to work with patients who had been waiting longer than 120 days on a surgical waitlist. We also received referrals from services that weren't on the Planned Care Pathway, where clinicians felt patients needed just a little bit of extra help.

So, in terms of methodology for this project, we collected data. Our main job for the nursing team is to walk alongside our patients once they're waitlisted for surgery, and we collected data from their patients’ stories as we walk along and support them. Quantitative data was pulled from the system, from ADHB systems, to analyse to see where the areas that we prioritise to address the long waiting lists. We were also using action learnings for the teams to test some hypotheses that we came up of what possible problems that our people face and solutions that could come out of this.

We developed models of care, as data came in, and developed service blueprints to underpin improvement models and guide our practice. And along the way, the nursing teams were trained and received a lot of support from our performance improvement team on data, how to collect data, and how to report the data that we have collected to all of our stakeholders. The key performance indicators for the project was: we look at the proportion of patients waiting over 120 days; the proportion of surgeries that were converted to acute procedures; the proportion of patients not attending surgery, and lastly, from the stories that we gathered from our people in our whānau.

So, the results. The data that we analysed from the time period of July 20 to May 21, it showed a reduction in the proportion of patient-related late cancellations for Māori, for Pacific and the rest of our population as well. In terms of volume proportion of patients waiting over 120 days for surgery, again, significant improvement in the Māori population and the Pacific population, as well as others.

So, in terms of the mean days, waiting time for surgery, during the project time, actually, for all population groups, they went up. And we think this is when COVID hit. During our project, COVID came along and, basically, everything was put on hold and ended up in longer waiting time for our … Māori and Pacific, and everybody else, while we diverted resources to attend to other areas of the hospital before we came back and picked up where we left off. In terms of reduced – sorry, of conversion to acute surgery, it's interesting. It shows during the project period, there was no difference for Māori.

For the Pacific population, there was a huge drop. So, this is when we think – or my theory is this is when because of interventions from support from the Planned Care Team, Pacific Planned Care team, that it made a difference to Pacific people, when they understood what they were coming for, the type of surgery they were doing, the support that we gave them, actually ended up in them attending surgery.

So, from the data that we gathered from the patient stories, we identified a number of areas that our people and system issues that our people face. A lot stemmed from poor communication between our services and our patients. There were late bookings as well of appointments and surgeries. We book appointments – we book surgeries according to the system, how it benefits us and our working hours. It wasn't family focused; it wasn't whānau focused. There was lack of whanaungatanga and manaakitanga. We didn't reach out and connect to our patient and understand their issues, understand how their family situations are and book according to their needs.

Very much what we did was based on our system within ADHB. We identified that transport and parking were an issue for some people. For the Pacific population, language barrier was a big issue; for older people waiting for surgery. There was a lot of misunderstanding of clinical information. A lot did not understand about – many did not understand about pre-op, preparation for theatre, post-op recovery, the expectations of them, where do they come to the hospital on day of surgery, what was the expectations of them? The nil-by-mouth policy, for example. And so, as a result of that, there was huge anxiety and fear of coming to the hospital system. And we were able to support them with that.

So, all the data that we collected also help us to develop some models of care for both teams that guide our practice going forward. We learned a lot of lessons from this project. Firstly, a project of this type, equity focused project was – it required a huge cultural shift within the organisation in the way we work. This was a new project ADHB, the executive, and the leadership of ADHB decided to undertake with a massive undertaking. And from where we were at the beginning, having to talk to services about this project, and we met a lot of resistance, a lot of scepticism in the beginning: people didn't understand what equity was all about. So, we learnt a lot over this time period. We learned that it required strong leadership and support and commitment from everybody, from all staff, in order for this equity focused project to succeed. Having high-quality support and data was crucial for this. The success of the planned care teams for both of us was partly because we have a lot of support from the performance improvement team; they came with expertise, IT expertise, data gathering and analysis and how to do report writing for our nurses. We learned a lot over this time period.

Workforce development, specifically for Māori and Pacific, this was a good opportunity for them to progress along career pathway. All the nurses become clinical nurse specialists, and then we develop them along the pathway as we go along. The implications of COVID also was a huge lesson for us. It created a lot of challenges, as we've heard before, and also created opportunities. We learn to work differently.

So, in conclusion, ADHB undertook – this was a massive undertaking to respond quickly to the inequities that existed within our planned care pathway for Māori and Pacific; and we proved that it was possible to address the inequities. It's work in progress, but it was a good start. This was a huge opportunity for us to collect good evidence about the barriers that our people face. We see it a lot. There was a lot of hearsay, but until we had the project, we went out and collected good data for ADHB, and we learned a lot about what it is like for Māori and Pacific people to come through the hospital system.

We also learned about system issues that we, in the organisation, experienced, but we didn't know there were issues until our people told us that these were issues that they face. And so, we were able to address them appropriately. There is a huge positive cultural shift within the organisation, from where we start to where we are now; a lot more close collaborations with services; clinical leads are on board with this project right now.

We learned to address inequities, we have proved that specific supports are needed for the specific populations; we are not all equal. Population groups within the organisation needed specific supports, and we have demonstrated that Māori needed different kinds of support; the Pacific people need a lot of support from nurses that speak their language and understand the culture. And as a result, our approach was evaluated, and it's now become business as usual for the organisation. And lastly, COVID 19 has taught us a lot of lessons. It has taught us to be adaptable and flexible. We are building on our successes that we have achieved so far. It has taught us to be more collaborative. We have good relationships, better working relationships with all the services that we work with within ADHB, and we keep going, and we have equity as a focus. Thank you, Malo 'aupito.

Thank you, Pauline and Mylee. That was a very interesting presentation with lots to share. We actually are running a bit short on question time, so I'll just ask one question, and perhaps, if you want to go into the chat and see if you can answer the questions. But, during your project, how many patients did each team support?

Hundreds.

On top of our minds, on top of our brains, it's a few hundreds.

A few hundreds?

Because basically, it's all across surgical services.

Just one more? Gillian?

Yes.

OK, fantastic work. What do you think works best to change the culture and achieve these great results? What do you see as the next major step in this process?

I think having the support of the executive team, the board and the leadership really helped to move this project along, and I think now that we've become business as usual, there's lots of avenues that we can move into. One of them comes to mind is medical: there's an area to help with the acute patients, or even the medical patients on the ward. But we're also moving into cancer and blood, the community. So, hopefully, that won't be too far away as well.

Yeah, I also want to add very quickly that cultural change does take time, and we basically – we've got to know each other. In terms of the people in the organisation, we've got to know a lot of people; we've developed good relationships over the past two years; and, with that, it actually helped the work that we do.

Yeah.

Fantastic. Thank you very much.

Thank you very much, you two. And those last words, we totally agree. The culture and the organisation, networks, relationships, forming trusting relationships and what often are the key foundations of being able to take different and new steps and to improve services. Thank you very much.

Just a thank you to everyone that's come to our sessions over the last five weeks, the four sessions. We're really appreciative of it. We'd always be interested in people who have topics that you think that we could also do, perhaps a short series on in the future. Would be really interested to know and understand what some of the current things that you would like to know about.

Again, thank you on behalf of all of the Commission. And Jane's going to close us with a karakia. Thank you, Jane.

Thank you, Gillian.

Kia ora anō tātou katoa.

Kei te whakakapi au i tā tātou hui

Nō reira he karakia whakamutunga

Kua mutu ā tātou mahi

Ka tae te wā

Mō te whakairi te kete

I te kete kōrero

I te kete whakaaro

Hei tiki atu anō mā tatou

Tauwhirotia mai mātou katoa

Ō mātou hoa

Ō mātou whānau

Āio ki te Aorangi.

Hui e tāiki e.

Kia ora.