MANATŪ HAUORA
MINISTRY OF HEALTH

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27 January 2023

s 9(2)(a)

By email: s 9(2)(a)
Ref: H2022018291

Tēnā koe s 9(2)(a)

Response to your request for official information

Thank you for your request, which was transferred from Te Whatu Ora - Health New Zealand to Manatū Hauora (the Ministry of Health) on 12 December 2022 for information about the emergency department (ED) waiting time target. Please find a response to your request below:

> *"(I) any reports, memorandums, agendas, minutes that detail the establishment of waiting*
> *time targets around the end of the year 2009 or the start of 2010.*
> *(II) any reports, memorandums, agendas, minutes, emails that request a change to the establishment of wait times targets over the last 5 years.*
> *(III) any reports, memorandums, agendas, minutes, emails that graph or show data of the*
> *wait times in the last 5 years.*
> *(IV) any reports, memorandums, agendas, minutes, emails that graph or show data of the*
> *wait times targets in the last 5 years.*
> *(V) any reports, memorandums, agendas, minutes, emails that discuss changes to reporting methods of the wait times targets, in the last 5 years."*

On 15 December 2022, you were contacted by Manatū Hauora to refine your request, as it would likely require a substantial amount of time to collate and may be refused under section 18(f) of the Act. On 19 December 2022, you agreed to refine your request to:

> *Final briefings about ED targets that address the nature of your request and historic data regarding waiting time targets for the period of your request.*

Manatū Hauora has identified 14 documents within scope of your request. All documents are itemised in Appendix 1 and 2 with copies of the documents enclosed. I note that documents numbered 10 to 13 relate to the replacement of the suite of health targets (including the ED target) with the health system indicator measurement and improvement framework.

Where information is withheld under section 9 of the Act, I have considered the countervailing public interest in release in making this decision and consider that it does not outweigh the need to withhold at this time.

Although you have requested data for the ED waiting time target from the last five years, I have decided to provide you with data from the period of 2009/10, as this was when the targets were first established. This data reflects the changes in waiting times performances over the years.

Please note in Document 7, the Health Targets 2009/10 Report is publicly available at: www.moh.govt.nz/notebook/nbbooks.nsf/0/BA51FF94147D2889CC2576820000CD98/$file/health-targets-0910-nov09-v3.pdf.

Further information regarding current waiting times in emergency departments is available on Te Whatu Ora website at: www.tewhatuora.govt.nz/about-us/publications/national-performance-reporting-metrics-dec-2022/.

I trust this information fulfils your request. Under section 28(3) of the Act, you have the right to ask the Ombudsman to review any decisions made under this request. The Ombudsman may be contacted by email at: info@ombudsman.parliament.nz or by calling 0800 802 602.

Please note that this response, with your personal details removed, may be published on the Manatū Hauora website at: www.health.govt.nz/about-ministry/information-releases/responses-official-information-act-requests.

Nāku noa, nā

PP 

Robyn Shearer
Deputy Chief Executive & Deputy Director-General
System Performance and Monitoring | Te Pou Mahi Pūnaha

Appendix 1: List of documents for partial release

#	Date	Document details	Decision on release
1	19 December 2008	The Working Group for Achieving Quality in Emergency Departments – Final Report	Some information withheld under section 9(2)(a) of the Act, to protect the privacy of natural persons.
2	20 February 2009	Report from the Working Group for Achieving Quality in Emergency Departments – Outcome of Consultation (HR20090257)	
3		Improving the Quality of Emergency Department Services – Next Steps (HR20090258)	
4	17 April 2009	DHB Feedback on New Health Targets for 2009/10	
5	20 July 2009	Update on the Shorter Stays in Emergency Departments Health Target (HR20091268)	
6	1 October 2009	Health Targets – 2008/09 results and 2009/10 publication (HR200915817)	
7	10 November 2009	Publication of the Health Targets 2009/10 Summary Report (HR20092142)	
8	2009-2010	DHB Reporting Requirements 2009/10 Final	
9	14 December 2010	Update on progress and activities to support achievement of the shorter stays in Emergency Departments Health Target	
10	20 December 2017	Potential next steps to reshape and refresh health targets (HR20171714)	
11	22 January 2021	Briefing: Cabinet paper Implementing Health System Indicators – a new measurement framework for publicly reporting health system performance (HR20210013)	
12	31 May 2021	Briefing Health System Indicators Framework – Implementation approach and sector feedback (HR20211225)	

#	Date	Document details	Decision on release
13	8 December 2021	Health System Indictors Framework – consultation findings (HR20212680)	

Appendix 2: List of documents for full release

#	Date	Document details	Decision on release
1	2009/10-2021/22	Shorter stays in Emergency Department Performance (spreadsheet version)	Released in full

Document 1

MINISTRY OF HEALTH
MANATŪ HAUORA

Action required by:	9 January 2009	**Date sent to Minister:**	19 December 2008
Minister's reference/ OIA number:	N/A	**File number:**	HC07-01-1

Hon Tony Ryall
The Working Group for Achieving Quality in Emergency Departments – Final Report

A Working Group Focused on Emergency Department Quality is Ready to Report its Findings

1. This Health Report provides you with a copy of final advice and recommendations submitted by the Working Group for Achieving Quality in Emergency Departments (Working Group), so that you are aware of the Working Group's outputs, and can indicate to the Ministry of Health (Ministry) if, and how, any recommendations should be implemented. Please find the Working Group's report (the Report), "Recommendations to Improve Quality and the Measurement of Quality within New Zealand Emergency Departments", enclosed.

2. This Working Group is administered by the Ministry, and Chaired by Geraint Martin, Chief Executive Officer (CEO) of Counties Manukau District Health Board (DHB). It was started in order to develop recommendations for you based on main ideas from a workshop held with sector representatives in May 2008 (refer to HR 20081611).

3. The Ministry views production of the Report as part of an ongoing service review of hospital-based emergency services, due to report to Cabinet in 2009.

4. This Health Report briefs you on the main ideas in the Report, and gives possible options for the implementation of the recommendations it contains.

The Working Group Advises that Pressures on Emergency Departments are Real and Growing

5. Based on the medical literature, anecdotal reporting, personal experience, and limited systematic research, The Working Group finds that many New Zealand EDs face problems of patient overcrowding and long patient stays.

6. ED attendance figures and average length of stay data reported by DHBs to the Working Group show that over the five years from 2003/04 to 2007/08, numbers of presentations to EDs grew by19.9 percent, and total hours spent by patients in EDs grew by 34.4 percent. These growth rates are greater than for population growth (6.7 percent) and inpatient acute discharges (11.5 percent).

7. Definitive figures to demonstrate whether staff and bed numbers are keeping pace with this increase are not available.

8. Much more could be done to quantify, validate, and study the problems raised by the Report. Nevertheless, the Ministry advises you to accept the Report as representing the best available description of challenges currently facing New Zealand EDs.

The Working Group Has Made Fourteen Recommendations to You

9. The purpose of the Report is to convey to you a set of ideas that the Working Group believes can make a difference to the quality of ED services. A summary of these fourteen recommendations is found on pages 5-7 of the Report.

Document 1

10. The first five recommendations relate to the setting of standards and expectations for ED service quality (a six-hour length of stay health target, and requirements to eliminate ED corridor stays and ambulance ramping), for which DHB CEOs can be held accountable. The Ministry supports this approach.

11. Recommendations 6 and 7 ask that a Ministry locus and sector network be established to work together on an integrated programme for service improvement. This will certainly be required if a health target regime is implemented, and would enhance the potential for real success in the sector.

12. Recommendations 8 to 10 are for local implementation.

13. Recommendations 11 to 14 suggest that further work is required in strategic planning, workforce and capital, and research. Some of this could be progressed within existing Ministry workstreams.

The Ministry is Broadly Supportive of the Report, but Also Advises You of the Shortcomings and Risks

14. The Ministry supports the thrust of the report. Furthermore, it was developed following extensive consultation with the ED workforce. If recommendations could be accepted in large measure, it would indicate willingness on the part of government and Ministry to listen and co-operate. At the same time, this Report marks the start of a process rather than the end, and much more work is required, as implied by paragraphs 15 to 17 below.

15. *The scope and methodology of the Report has limitations.*

    a) The Working Group consciously sought to limit its thinking to improving the quality of ED services. This means that other providers of acute services (such as primary care, diagnostics, ambulances and inpatient hospital care) are not considered, except insofar as they have an impact on EDs. This is a document detailing a plan for ED quality improvement, not an acute care strategy. The government and Ministry have a role in ensuring that developments across all health services providing acute and emergency care are coherent and provide a strong integrated system.

    b) Several relevant ideas are not discussed by the report, or mentioned peripherally, including: ways of reducing admission rates from ED to inpatient wards; the co-location of GP surgeries with EDs; and the possibility of protocols for the referral of patients away from EDs to primary care.

    c) The Report contains extended discussion of survey data collected by the Working Group. This data supports the advice given. However, this data has not been validated. There are discrepancies with District Annual Plan planned ED volumes and with data previously submitted for Hospital Benchmark Information.

16. *There are significant risks associated with implementing the recommendations.*

    a) There is a possibility that the pressures of a target regime will lead to expectations of workforce increases that are unaffordable or unjustifiable.

    b) There is a possibility that a 'no corridor stays' approach will cause DHBs to approach capital planning based on peak occupancy rather than average occupancy. This is not affordable. Capital planning should proceed on the basis of 85 percent average (not peak) occupancy, with accompanying work to develop plans for peak capacity and to smooth variation it patient occupancy.

    c) A lack of appropriate central (Ministry and government) support and resourcing to meet new expectations could result in little change, and subsequent demoralisation of the ED workforce.

    d) As always, game-playing by actors in the system is a possibility in a target-based system, and careful design of the framework is required to minimise this.

17. *Further research is required in many areas covered by the recommendations, including those listed here.*

    a) Research into the drivers of the growth in ED presentations. It is likely to be more complex than the frequently invoked hypothesis of primary care patients presenting for free treatment.

    b) Further research of the full capacity plan concept, perhaps including the following questions: who already has a plan, which ones are effective and which are not; what percentage of time do hospitals currently spend at full capacity, and what percentage should be considered as acceptable (given that capital planning cannot be based on peak demand)

Document 1

c) Research of the workforce and capital investment implications of the recommendations. This could include learning from the English experience of targets, and a review of the methodologies used to model ED capacity and hospital bed numbers in order to account for the impact of Admission and Planning Units (APU) and other specialised facilities.

The Ministry Has Considered How to Implement the Working Group's Recommendations

18. The table below lists each of the recommendations of the Working Group, along with a Ministry view of each recommendation's value, and a potential pathway for implementation. The Ministry will look to you for direction concerning whether or not you wish to accept the Working Group recommendations in whole or in part.

№	Recommendation	Ministry View	Possible Implementation Pathway
1	A health target for ED performance should be introduced.	Strongly supported.	Incorporated as part of the current work to redefine health targets according to 'better-sooner-more convenient'
2	The measure should be based on length of stay. The preferred form is percentage of patients admitted, transferred or discharged within six hours.	Strongly supported. Ministry supports the detailed proposal included in the body of the Report.	According to limited research carried out at this point, it is probable that most DHBs would find it technically possible to measure this form of health target in 2009/10. The clinical value of reductions in length of stay can be explored by the Ministry service review.
3	Triage rate measures should be retained and expanded to triage categories 4 and 5.	Strongly supported. Only currently available measure of time to treatment.	These measures will be considered further as part of the re-evaluation of all performance measures collected by the Ministry. If measures are retained, steps can be taken to obtain this information at patient level through national collections. This could be implemented from 1 July 2010.
4	Remove patients from ED corridors through use of full capacity plans.	Supported.	Further evidence showing the worth and advisability of this approach should be obtained prior to implementation. The literature evidence should be explored further by the Ministry service review. If supported by evidence, full capacity plans can then be mandated by the Ministry.
5	No ambulance ramping.	Strongly supported.	Could be enforced through service level agreements, or expectations could be set through service specifications. If monitoring of this area proves desirable, this may be possible through performance and KPI frameworks developed as part of the emerging ambulance strategy.
6	A Ministry locus required.	Strongly supported.	One option is a Health Target Champion with a supporting team.
7	A corresponding sector clinical network.	Strongly supported.	Shape to be determined by the Ministry. Would need to be considered in line with Long-Term Systems Framework development. A sector clinical network would ideally span a wide range of stakeholders from across the acute care continuum, to address system-wide issues.
8	Stable GP referrals go directly from triage to inpatient services.	The case for APUs is not proven, but the underlying principle is sound.	Further evidence is required of the usefulness of APUs. The clinical and financial value of APUs could be examined and quantified by the Ministry service review, including investment requirements. The Report primarily intends this for local implementation by DHBs.
9	Strong relationships between EDs and primary care.	Strongly supported.	The Report primarily intends this for local implementation by DHBs.
10	Local data analysis should help identify pressure points.	An operational DHB issue.	The Report primarily intends this for local implementation by DHBs.

Document 1

11	Integrated strategic planning of acute care services led by the Ministry.	Supported.	The Ministry can prioritise this for development through the Long-Term Systems Framework. However, some work would be required to determine the degree to which service planning is a local or national activity – the data provided by the Working Group shows wide variation in ED trends across the country. One possibility is the establishment of an 'Acute Care Summit' in 2009 to look at issues with the sector and establish a basis for future work. This links to recommendation 13; an acute care plan at the local level should ideally precede capital planning.
12	Development of staffing models.	Supported.	Refer the Report to the Strategic Workforce Development Unit for inclusion in future work programmes.
13	Capital developments should reflect current understanding of best practice.	Supported.	Refer the Report to the Ministry Technical Review Group for use in the assessment of facility configurations.
14	Research is required, especially into growth in ED presentations	Strongly supported.	There are gaps in the current evidence base, which new research could fill.

Recommendations

The Ministry recommends that you:

a) **Note:** the report "Recommendations to Improve Quality and the Measurement of Quality in New Zealand Emergency Departments", written for you by the Working Group for Achieving Quality in Emergency Departments. Yes / ~~No~~

b) **Indicate:** whether you wish to have a verbal briefing from the Ministry of Health about this Report. Yes / ~~No~~ with senior ED specialists

c) **Accept:** the advice given to you by the Ministry of Health concerning which recommendations of the Report to accept, and any caveats. Yes / ~~No~~

- The Ministry supports or strongly supports all recommendations, but places caveats on recommendations 4 and 8.
- Further research or evidence supporting the usefulness of recommendations 4 and 8 is required before the Ministry would advise implementation.

d) **Note:** that an ongoing service review of hospital-based emergency services being carried out by the Ministry of Health will develop further advice and recommendations during 2009. Yes / No advise more

e) **Agree:** to development by the Ministry of Health of more detailed proposals for implementation of each recommendation in the Report, where implementation is relevant at a national level. Yes / ~~No~~

Anthony Hill
Deputy Director-General
Sector Accountability and Funding

Ryan

MINISTER'S SIGNATURE:

DATE: 19.12.08

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Document 2

MINISTRY OF HEALTH
MANATŪ HAUORA

Action required by:		**Date sent to Minister:**	20 February 2009
Minister's reference/ OIA number:		**File number:**	HC07-01-1

Hon Tony Ryall
Report from the Working Group for Achieving Quality in Emergency Departments – Outcome of Consultation

1. The purpose of this report is to provide analysis of responses to a consultation on the document *Recommendations to Improve Quality and the Measurement of Quality in New Zealand Emergency Departments* (ED Quality Report). This is so you can be informed about the outcome of this consultation prior to decisions being taken about future action relating to emergency departments (ED).

2. The ED Quality Report was presented to you by the Working Group for Achieving Quality in Emergency Departments (Working Group) on 19 December 2008 (refer to HR 20082553). You subsequently released the Report and asked for a public consultation by 13 February 2009.

3. Further to this Health Report, a summary of consultation responses will be prepared for circulation to respondents. This will be shared with your Office, as well as circulated to members of the Working Group.

4. This Health Report will be followed by another, HR 20090258. This will give recommendations for the next steps that should be taken to drive improvements in the quality of ED services.

Overall response to the ED Quality Document was positive

5. Seventeen respondents made a submission to the consultation within the time period permitted. This included seven District Health Boards (DHB), four other healthcare groups, five clinicians responding in an individual capacity, and the Health and Disability Commissioner. Most spoke of the ED Quality Report in positive terms.

6. The requested format for consultation submissions asked, for each of the 14 recommendations in the report, whether respondents agreed or disagreed with the recommendation. The table overleaf summarises the level of support for each recommendation, by summing the numbers of respondents who agreed or disagreed with each recommendation, along with the number whose response was unclear. As will be apparent from the table, most recommendations in the ED Quality Report had widespread support.

7. Recommendations eight, six and 13 were the most poorly supported, in that order. Recommendation five was the only recommendation with total and unqualified support from all respondents.

8. You should bear in mind that this count is necessarily somewhat artificial, since a respondent supportive of a recommendation may nevertheless list a number of caveats and weaknesses with the recommendation, while a respondent who disagrees with the recommendation may nevertheless acknowledge its positive aspects.

Major recommendations had good support from respondents

9. While this is not stated in the ED Quality Report, the Working Group's own perception of its work was that the proposal of a health target (recommendations one and two) was its most significant contribution, followed closely by other service standards covered by recommendations three to five. This section summarises main messages and themes expressed in response to these chief recommendations.

Document 2

Table: Numbers of respondents who agreed or disagreed with each recommendation. The total count of responses varies, because not all respondents commented on each recommendation.

Recommendation	***Agreed***	***Unclear***	***Disagreed***
1. There should be an ED health target.	14	2	-
2. The health target should be based on ED length of stay.	12	3	1
3. Current reporting of ED triage rates to the Ministry of Health (Ministry) should be retained (and expanded).	13	-	2
4. Corridor stays should be eliminated, through the use of full capacity plans.	15	1	-
5. Ambulance ramping should be considered unacceptable.	15	-	-
6. A Ministry Locus should be established to implement the programme of work implied by other recommendations.	8	4	3
7. A sector network should be established to work with the Ministry Locus.	12	2	1
8. Stable GP referrals should be transferred to inpatient services following triage.	8	2	5
9. Relationships should be developed with primary care that provide strong pathways of care between EDs and care outside hospital.	14	2	-
10. EDs should analyse data to identify pressure points, potentially using 3-2-1 methodology.	13	1	1
11. Strategic acute care planning should take place at local, regional and national levels.	14	1	-
12. Innovative workforce models should be developed for EDs and acute primary care provision.	12	3	-
13. Bids for capital development should be evaluated in light of other recommendations in the ED Quality Report.	8	6	1
14. Further research should take place, particularly of the drivers of ED attendance.	14	-	1

10. The proposal of a *health target based on ED length of stay* (recommendations one and two) had wide support as a useful tool to drive change. The following themes emerged from responses to these recommendations:
    - this should be seen as a whole-system target, not just the responsibility of EDs
    - resources to meet the target would be helpful, such as beds, programmes to improve efficiency and staff utilisation, and advice on practical steps that can be taken locally
    - this will be a challenging target
    - it would be useful for this target to be part of a range of performance measures covering the whole patient journey.

11. Some concerns were also voiced, over the potential for gaming, issues of comparability between EDs, and information system capacity in some small centres. In addition, two alternatives to a target-centred approach were proposed (though neither respondent totally excluded use of a target from their approach):

    "We suggest negotiations at a local level so that practical steps are in place to ensure people do not wait unnecessarily and are cared for in the safest place.... Suggest that a principle approach [*sic.*] may provide DHBs with flexibility to achieve the same end." (Hutt Valley DHB)

    "This target will simply create a focus on moving patients, not treating them.... It will tell you nothing about the quality of care that they received.... Many DHBs are now incorporating lean thinking principles into the design of their services, and I would like to see some courageous actions at national level.... I would support a national campaign to improve a patient journey for one group of patients – perhaps one journey each year." (DHB Lean Thinking Manager, speaking as an individual)

Document 2

12. Recommendation three, that triage reporting be retained and enhanced, was supported except in two cases: one respondent recommended a move to a two-level triage system; another felt triage rates show DHBs in a poor light and DHBs should be given time and practical solutions to find improvement.

13. Recommendation four had two parts: the elimination of corridor stays; and the use of full capacity plans to achieve this. All respondents agreed that corridor stays represented poor care. However, some felt that speaking of 'elimination' was impractical given current resources, and one respondent felt this language could not be sustained in principle – after all, the practice of moving patients to wards or discharging them requires them to wait on a trolley momentarily till a porter arrives, etc.

14. Full capacity plans were also viewed by respondents as sensible, but with caveats – in the words of the New Zealand Nurses Organisation (NZNO), "there will be no improvement to patient safety if patients are merely transferred from one unresourced corridor space to another equally unresourced … space… in the inpatient service."

15. Recommendation five, regarding ambulance ramping, received unequivocal support from all respondents. In this regard, St John and Wellington Free Ambulance (in two separate submissions), both suggested that the ED length of stay target be measured from the time of ambulance arrival at ED. However, given that the IT systems of the ambulance services and EDs are not integrated, the view of the Ministry is that this proposal may prove too technically challenging.

The most poorly supported recommendation related to GP referrals

16. Recommendation eight, that "Following triage, stable GP referrals should be immediately directed to, and treated by, inpatient services", was rejected by many respondents. Reasons included the following:
    - the ED Quality Report was perceived to give too much emphasis to the Admission and Planning Unit (APU) service model and this was not seen as relevant to smaller centres
    - some respondents felt that GP referrals are most competently assessed by ED clinicians rather than inpatient specialists, at least in some cases
    - two respondents felt an APU model results in a two-tier quality of care: one felt those rich enough to access a GP were unfairly favoured, as they go directly to the APU; another felt GP referrals were discriminated against, as they would not have the benefit of ED expertise and timely treatment.

The NZNO submission outlined a distinctive perspective

17. The NZNO represents a significant group of ED staff, and its submission viewed ED challenges from a different perspective to others, in which the workforce challenges were seen as the primary issue:

    "We agree that Section 1 of the report has correctly identified some of the key problems in emergency departments…. However we believe that safe staffing (or rather "unsafe" staffing) should be identified as the key issue underlying all these problems." (NZNO)

18. The NZNO highlighted the work of the NZNO Safe Staffing/Healthy Workplaces Unit, which is working with DHBs and the Ministry to develop safe staffing protocols during times of hospital overload. It would be sensible for future work on ED issues to take account of this Unit, and in particular it is pertinent to any future action on full capacity plans (the Unit is focused on staffing limitations to safety, the full capacity plan concept focuses on bed limitations).

19. The NZNO is the only respondent to have strongly criticised any of the advice in the ED Quality Report (as opposed to the Report's recommendations). In particular, it is "at a loss to understand" the ED Quality Report's position on workforce trends (that is, that the available workforce data is too scant to allow conclusions to be drawn), and is insistent that ED nursing numbers are static. The Ministry has checked NZNO statements against information held by the Health Workforce Information Programme, and can confirm the ED Quality Report position; available data is too poor to allow trends to be determined.

Document 2

The Ministry is developing its response to the challenge of improving ED service quality

20. As stated earlier, a companion Health Report (HR 20090258) will outline the Ministry's recommendations for future action relating to EDs. This will take account of, but not be limited by, the ED Quality Report and the consultation responses received.

Recommendations

The Ministry recommends that you:

a)	**Note:** the information contained in this Health Report	Yes / ~~No~~
b)	**Note:** that a summary of all responses to the consultation on *Recommendations to Improve Quality and the Measurement of Quality in New Zealand Emergency Departments* will be shared with your office once this has been prepared	Yes / ~~No~~
c)	**Note:** that a companion Health Report (HR 20090258) will provide recommendations about future action relating to EDs	Yes / No
d)	**Indicate:** if you wish to receive any further information on the consultation, beyond the analysis provided here, and the summary of all responses	~~Yes~~ / No

Stuart Powell
Acting Deputy Director-General
Sector Accountability & Funding

Dr Ashley Bloomfield
Acting Deputy Director-General
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MINISTER'S SIGNATURE:

DATE: 23.2.9

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Document 3

Health Report Number: 20090258

MINISTRY OF HEALTH
MANATŪ HAUORA

Action required by:	27 February 2009	**Date sent to Minister:**	20 February 2009
Minister's reference/ OIA number:	N/A	**File number:**	HC07-01-1

Hon Tony Ryall
Improving the Quality of Emergency Department Services – Next Steps

1. This Health Report provides you with recommendations intended to drive improvements in the quality of emergency department (ED) services in New Zealand. These recommendations cover the introduction of a health target for ED services, and initial proposals for a package of measures designed to assist District Health Boards in achieving the target (along with achieving better service quality).

2. It is worth stating from the beginning that these two aspects of the Ministry's recommendations go hand-in-hand. This report proposes that you to place high-level, challenging, and publicly visible expectations on DHBs to deliver improvements. This will need to be accompanied by a strong programme of work to support DHBs in delivering improvements.

3. The report has been prepared in response to your indications that emergency department services are a priority, and more particularly to provide direction following consultation over the report *Recommendations to Improve Quality and the Measurement of Quality in New Zealand Emergency Departments* (ED Quality Report), sent to you under cover of HR 20082553. The consultation on this document closed 13 February 2009, and you requested the Ministry to provide recommendations by 20 February 2009.

4. A companion Health Report (HR 20090257) has been prepared describing outcomes of the consultation. Broadly speaking, the consultation submissions were supportive of the thrust of the ED Quality Report.

5. Recommendations in this Health Report have grown out of the ED Quality Report and the subsequent consultation, but are not limited solely to consideration of that document's contents. Rather than responding point-by-point to the 14 recommendations in the ED Quality Report, the Ministry here sets out its thinking regarding an integrated approach to improving ED service quality. In so doing, it will implicitly address most of the recommendations contained in the ED Quality Report.

6. At the same time, you should note that the proposals outlined in this Health Report are not yet fully developed. What is emerging is potentially a complex body of work that will take time to develop into a fully realised plan.

7. This report is structured around two central ideas: a health target, and associated expectations; and support for the sector to deliver desired outcomes. In turn, the latter part of the report is divided into two sections: a plan for engaging collaboratively with the sector around service quality improvement; and possible Ministry-based initiatives that would facilitate improvements in the sector.

Prompt Roll-Out of an Emergency Department Health Target

8. You have previously indicated your interest in a health target for EDs. Such a health target was the principal recommendation of the ED Quality Report, and sector support for this measure has been confirmed by the formal consultation on the Report. The Ministry concurs that introduction of such a target is a reasonable approach, and recommend that you formally instruct the Ministry to proceed with implementation.

Document 3

Details of the Proposed Health Target

9. In response to your previous signals regarding an ED health target, the Ministry has prepared documentation for the DHB planning package for the 2009/2010 year, describing and defining the health target. This is ready for immediate use, and will be shared with DHBs once you have agreed to implementation of the target.

10. The nature of the health target closely follows the recommended form outlined in the ED Quality Report (recommendations 1 and 2), and further advice was sought from the working group while refining planning package documentation. The relevant documentation is appended to this health report. The main features of the proposed target are as follows:
    - the target measures the percentage of patients admitted, discharged, or transferred from an ED within six hours
    - beginning in the first quarter of the 2009/2010 year, DHBs are expected to set their own targets for the percentage of patients processed within this six-hour window, for the five quarters up to and including the first quarter of the 2010/2011 year
    - these self-set targets will track a trajectory for the DHB towards a mandatory universal target of 95 percent of patients processed within six hours, which must be met in the second quarter of 2010/2011, that is, by the end of the 2010 calendar year
    - DHBs will negotiate their proposed self-set targets through the 2009/2010 District Annual Plan process.

11. In agreeing to this target, however, you should be aware that implementation carries financial risk. It is possible, if not likely, that DHBs will respond to a target by requesting additional resources such as beds and capital projects, in order to meet target standards. At this stage the Ministry has not carried out an economic analysis of the likely impact. It is unknown how much gain can be obtained through efficiencies and better operating practices in the health system, and how much resource is legitimately required to raise standards. Identifying the potential cost of achieving the target will be a part of the discussion with individual boards when negotiating their self-set targets.

Public Communication About the Health Target

12. We advise that in interactions with the media and public, this be referred to as the *ED length of stay target* (c.f. the 'ED waiting time target'). This is because the six-hour benchmark is a measure of total time in the ED, much of which may be legitimate time spent on assessment and treatment of the patient, rather than just waiting. In addition, the experience of the Ministry is that the media can find the term 'waiting time' confusing if applied to length of stay, and partly because of this confusion, length of stay and bed block is frequently conflated in media reporting with national triage rate measures (waiting time to treatment).

13. Solutions to the problems of long patient stays and overcrowding in ED will come from across the spectrum of acute care services. It is worth emphasising in communication with the public that while this is called an ED health target, delivering improvements is a responsibility not only of ED, but of the whole health system.

Other Supporting Service Standards and Performance Measures

14. Additional standards and performance measures will be developed to complement the introduction of a health target. At this stage, the Ministry recommends that your immediate communications with the sector focus on the health target, while work in these additional areas is progressed; further measures can then be rolled out in a staged fashion.

    a) The Ministry will work with the sector to modify the status of triage rate measures, and improve their measurement, in line with recommendation 3 of the ED Quality Report. Triage rates are not currently a formal accountability measure, and limitations of the DHB planning cycle mean a change in status is not practical until the 2010/2011 year. In addition, the measures will require refinement and modification, both to extend their scope in line with the ED Quality Report, and to improve their clarity.

    b) Ambulance ramping is unacceptable (recommendation 5, ED Quality Report), and it is appropriate to take prompt steps to limit this practice. The Ministry proposes that a short-life group of sector

representatives be established to review the tier one Service Specification for Emergency Department Services. Such a review would provide an opportunity for a proscription of ambulance ramping to be built into core service standards through the service specification.

c) The Ministry and sector are in agreement that ED corridor stays represent sub-optimal care and that improvements in this area are desirable (recommendation 4, ED Quality Report). However, action in this area is complicated by several factors. For one, several respondents to the consultation over the ED Quality Report have made it clear that elimination of corridor stays (as opposed to reductions) would be very challenging in the short term. For technical reasons the level of corridor stays is not as easy to monitor as ED length of stay (the basis of the health target). In addition, different approaches to conceptualising and dealing with the issues of hospital overload are possible. While the ED Quality Report recommends full capacity plans (based on spreading patients across hospital beds), the New Zealand Nurses Organisation (NZNO), in conjunction with DHBs and the Ministry, is developing approaches to safe staffing during periods of heavy workload. The Ministry recommends further evaluation of different approaches before announcing any standards or action.

Ministry Support for the Sector to Deliver on Expectations

15. The Ministry will look to work with the sector to improve ED services.

16. This section outlines how the Ministry intends to support the sector to reach the health target and deliver improvements. This involves both externally-focused collaborative work with DHBs to improve service quality, and internal projects focused on improving the underpinning structures that facilitate good practice in the sector and ongoing improvement.

17. Overall leadership of this work will rest with Sector Capability and Innovation Directorate (SCI). It is envisaged that this will require dedicated project management and analytical support, and the involvement of a health target champion, who may be seconded from the sector for this role. The Ministry is currently pulling this team together. In addition, mechanisms will be established to involve relevant people from across the Ministry.

18. There is a clear focus on ED improvement, but the scope of the work programme will cover the acute care spectrum. Changes will have to be made across whole hospitals and the whole health system in order to bring about improvement in the quality of ED services.

19. All detail provided in this section is provisional, and the Ministry asks that you agree to further development of these ideas, with progress reports to you through the weekly report mechanism, and verbal briefings if required.

The Ministry Will Develop a Plan for Collaborative Working with DHBs

20. It is anticipated that the first stage of work with DHBs will be based around a range of national quality improvement programmes currently underway, or about to be launched. Participants in these programmes will be directed to focus their activity on designated areas of Ministerial priority, including ED.

21. After this initial work the Ministry will be better placed to determine what kinds of regional and national networks will be required in order to share information and drive change, and can begin to develop these. This may involve re-invigoration of the Emergency Care Co-ordination Team (ECCT) concept, first introduced through the *Roadside to Bedside* (1998) policy document. Links are also evident between this work and the Long-Term System Framework ambition to develop both service planning at regional and national levels, and clinical networks.

22. It is also likely that a method for audit of the results against the health target, and methods used to achieve them, will be required as part of the work programme with DHBs.

23. In addition to work with DHBs, the Ministry will explore involving other groups such as ACC and the ambulance sector.

Document 3

The Ministry will investigate the Potential of New Internal Workstreams

24. Besides externally focused work, there is potential for development of some Ministry-based initiatives to support improvements in EDs. The Ministry requires time to explore the viability and resource requirements of these activities. The following is an indicative list of possible areas for work.

    a) *Workforce*. The Ministry could investigate ways to facilitate better use of the ED advanced nursing workforce (a key issue for NZNO); carry out benchmarking of ED workforce data; and investigate current staff rostering models used by DHBs in order to share best practice.

    b) *Data collections*. Enhancements could be made to the National Non-Admitted Patients Collection (NNPAC) in order to collect more detailed patient-level data from EDs. By 2010/2011 this could enable more nuanced monitoring of ED length of stay data, and exploration of the relationship between length of stay and patient outcomes.

    c) *Capital projects*. One of the fundamental factors influencing ED length of stay is overall hospital bed occupancy. Ensuring that hospital bed numbers are appropriate is therefore an important step, and the Ministry relies on models of demand to decide on appropriate numbers of hospital beds when approving capital projects. It may be appropriate to review Ministry bed modelling in order to identify improvements.

    d) *Funding*. The Ministry could investigate and report on any potential incentives to keep patients in EDs longer than necessary, driven by current DHB funding arrangements. In addition, financial schemes to incentivise PHOs to keep their registered patients out of hospital could be developed.

    e) *Technology*. The Ministry could review how effective use of technology could improve ED services.

Document 3

Recommendations

The Ministry recommends that you:

a) **Note:** that this Health Report is a companion piece to Health Report 20090257, which describes the outcomes from consultation about the document *Recommendations to Improve Quality and the Measurement of Quality in New Zealand Emergency Departments*. Yes / ~~No~~

b) **Agree:** to the implementation of an ED length of stay health target of the kind described in this report. ~~Yes~~ / No

c) **Agree:** that the Ministry will discuss potential costs of achieving an ED health target with individual DHBs during negotiations over self-set targets. No self-targets ~~Yes~~ / No

d) **Agree:** that the Ministry work to enhance triage rate reporting prior to its elevation to a formal DHB accountability requirement for the 2010/2011 year. Standard ~~Yes~~ / No

e) **Agree:** that the Ministry arrange for a review of the tier one Service Specification for Emergency Department Services, as part of which the proscription of ambulance ramping could be incorporated. Yes / ~~No~~

f) **Note:** that the Ministry is undertaking work to develop a package of measures to support DHBs in reaching the health target and improving ED services, and that the details provided in this report about that package are provisional. Yes / ~~No~~

g) **Agree:** that the Ministry give you progress reports, via the weekly report mechanism, on all aspects of this report. Yes / ~~No~~

Stuart Powell
Acting Deputy Director-General
Sector Accountability & Funding

Dr Ashley Bloomfield
Acting Deputy Director-General
Sector Capability & Innovation

Ryan

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Document 4

MINISTRY OF HEALTH
MANATŪ HAUORA

Action required by:	Monday 20 April	**Date sent to Minister:**	17 April 2009
Minister's reference/ OIA number:		**File number:**	HC-01

Hon Tony Ryall
DHB Feedback on New Health Targets for 2009/10

Advice

1. The Ministry has, during the past week, sought feedback from the sector on proposed changes to the Health Targets. At your request, a letter was sent to District Health Board (DHB) Chief Executives, Chief Medical Officers and Chairs on Thursday, 9 April 2009, with feedback requested by 11am Thursday, 16 April 2009. (The letter is attached as Appendix 1.) These stakeholders were asked to comment on a draft set of six new Health Targets for 2009/10, and on the proposal that the existing targets that fall outside of this set be absorbed into a streamlined Indicators of DHB Performance (IDP) framework. (See Table 1)

Table 1: Proposed new Health Targets and IDPs

Proposed Health Targets for 2009/10	**Shorter stays in Emergency Departments**
	Improved access to surgery
	Shorter waits for cancer treatment
	Increased immunisation
	Better help for smokers to quit
	Better diabetes and cardiovascular services
Proposed IDPs	**Improved school dental service**
	Fewer unnecessary hospital admissions
	Better nutrition
	Better Mental Health services

2. This Health Report provides an interim summary of the feedback. It includes the feedback received from the 11 DHBs who commented by 5pm Thursday, 16 April 2009. The Ministry can update you by Monday with any additional feedback received. Appendix 2 provides a list of DHBs who have commented.

3. DHBs will be sent additional feedback on their District Annual Plans (DAPs) on Tuesday 21 April 2009. This presents an opportunity to confirm with them the target areas for 2009/10.

4. No respondent disagreed with any of the target areas, in principle. Some expressed active support, and some did not comment on the choice of target area, but gave comments about details such as how the targets are measured, definitions, implementation timeframes (some suggest a staged approach to allow them to develop appropriate information systems and staff capability), and whether they consider the target levels to be achievable. The consultation was at a high level, so did not include detailed planning information and details, and this is reflected in some of the questions raised by stakeholders.

5. The proposal to absorb the remaining 2008/09 targets into a streamlined IDP framework was strongly opposed by one DHB, and opposed by two who seem to have interpreted the change in name as meaning the introduction of new targets. There is strong support for reducing and streamlining the current reporting framework and overall administrative burden.

Document 4

Summary of feedback by target area

6. Shorter stays in Emergency Departments

- Four DHBs raised concerns about the degree of 'stretch' in the target, including whether the timeframe for implementation is realistic for them.

5. Improved access to surgery

- Concerns about achieving the target were raised by three DHBs, including Counties Manukau which suggested reducing waiting times over a three year period, and Taranaki which noted that achievement of the target will be difficult unless they continue to received increased funding for elective services.

- Several DHBs suggested the target should be reworded, including two who suggested it be called "improved access to elective surgery".

7. Shorter waits for cancer treatment

- There was general support for a target around cancer waits. However, Auckland argued that the target statement was too blunt an instrument and does not address the most disadvantaged Category B patients, who should be treated within two weeks.

- Concern about the implementation timeframe for this target was raised by Canterbury, and by Capital and Coast.

- Two DHBs noted that they would have to negotiate with the DHB which provides this service for their populations. Hutt Valley noted this would have to be a regional target.

- Taranaki commented that any improvements in cancer waiting times need to be linked to increased investment in capacity, and as such the target does not appear to be realistic.

8. Increased immunisation

- The Target Champion recommends that this target have an end-date specified, and that it be 95 percent coverage by 2012. The version on which DHBs were consulted (shown on the second page of Appendix 1) included no end-date, which some stakeholders interpreted as meaning that they needed to achieve 95 percent coverage by 2009/10. They expressed concern that this was over-ambitious, and would not be attainable.

- Two DHBs submitted that the target should be 95 percent of children whose parents have *consented* to immunisation. Northland in particular noted that 14 percent of their parents refused to have their children immunised during the MeNZB campaign. (net of those declining)

9. Better help for smokers to quit

- A number of stakeholders noted the need for clear definitions and careful measurement, and the risk that without these outcomes might not be meaningful. Some argued for a staged approach to allow time to get information systems in place and train staff.

10. Better diabetes and cardiovascular services

- Canterbury supported indicators (a) and (c) but strongly opposed indicator (b) (increased percent of people with diabetes attend free annual checks). It argued that an annual check is the wrong driver for better diabetes management and that its clinicians do not support the concept of a single disease annual check, noting that people with diabetes need horizontal management for co-morbidities on an ongoing basis.

20090632

- Some noted the importance of aligning this target with primary care activities (perhaps even making it explicitly a primary care target).

- Others noted problems with data collection and the need for clear definitions.

Summary of feedback on proposal to absorb 2008/09 targets into the IDP framework

11. Seven DHBs expressed comfort or made no in-principle comment about the proposal to absorb four of the 2008/09 targets into the IDP framework. Several had specific comments about definitions and measures for these as IDPs.

12. Three (Canterbury, Northland and Nelson-Marlborough) opposed the proposal to absorb the existing targets into the IDP framework.

    - Canterbury and Nelson-Marlborough have interpreted the change in wording to mean that these constitute new indicators, and are concerned about what they perceive might be an increased administrative burden. (It seems likely that this reflects communication issues rather than necessarily meaning a fundamental problem. The intention, as outlined in the letter sent to stakeholders, is to streamline and reduce the number of IDPs.)

    - Northland considers the existing Dental, Ambulatory Sensitive Hospitalisations (ASH) and Better Nutrition targets track significant issues for its population and/or are fundamental to achieving long-term health gains.

Recommendations

The Ministry recommends that you:

a)	**Note:** that this report summarises feedback received up to 5pm Thursday 16 April, from 11 DHBs, on proposed changes to Health Targets for 2009/10, and that you will be updated with any additional feedback received.	Yes / ~~No~~
b)	**Note:** that DHBs will be sent further feedback on their draft DAPs on Tuesday 21 April, and that this presents an opportunity to confirm the 2009/10 targets.	Yes / ~~No~~
b)	**Agree:** to meet with officials and decide on the 2009/10 targets on Monday 20 April 2009.	Yes / ~~No~~

Deborah Roche
Deputy Director General
Health and Disability Sector Strategy Directorate

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Appendix One Consultation letter sent to DHB CEOs, CMOs and Chairs, 16 April 2009

Document 4

Dear Colleague

As you may be aware, the Government is keen to simplify measures / targets / goals to better enable the health sector to focus on the delivery of front line services for patients and communities.

The Ministry of Health has been working closely with the Minister to achieve this. The Minister has asked us to write to you.

A major reason for change is that the new Government wants to reduce and simplify the current reporting framework and the overall administrative burden.

As the Minister told a recent conference: *The Ministry advises me that we are currently asking you to measure the performance and quality of our public health system through: 13 health priorities and 61 objectives, with an additional subset of 13 health objectives; a set of 10 targets measured through 18 indicators; 25 other indicators of DHB performance; not to mention 4 hospital benchmark indicators assessed through 15 measures; and an outcomes framework with 9 outcomes, measured against 39 headline indicators.*

We are now at the stage where we have a draft set of targets, and we are seeking your feedback on these.

It would be appreciated if we could receive your response by 11am on Thursday 16 April.

We are intending to recommend to the Minister that within each of the health targets there are agreed individual 'stretch' targets for each DHB.

The attached sheet summarises the proposed set of six targets. The existing targets that fall outside of this set are likely to be absorbed into a streamlined IDP framework.

We would be grateful if you could e-mail any comments through to Tracey More,
e-mail Tracey_more@moh.govt.nz

by **11am** on **Thursday 16 April**.

Yours sincerely

Deborah Roche
Deputy Director General
Health and Disability System

Ashley Bloomfield
Acting Deputy Director General
Sector Cabaility and Innovation Directorate

Document 4

Proposed Health Targets for 2009/10

Proposed target title	Proposed target
Shorter stays in Emergency Departments	95 percent of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours.
Improved access to surgery	To increase the average volume of elective surgery discharges per annum from an average 1,432 increase per annum, to an average 4,000 increase in elective discharges per annum.
Shorter waits for cancer treatment	Everyone needing radiation treatment will have this within six weeks by the end of July 2010 and within four weeks by December 2010.
Increased immunisation	95 percent of two year olds are fully immunised.
Better help for smokers to quit	90 per cent of hospitalised smokers are provided with advice and help to quit . Similar target for primary care from July 2010 or earlier, through the PHO Performance Programme.
Better diabetes and cardiovascular services	(a) increased percent of the eligible adult population have had their CVD risk assessed in the last five years (b) increased percent of people with diabetes attend free annual checks (c) increased percent of people with diabetes have satisfactory or better diabetes management.

Proposals for existing 2008/09 Targets, to be absorbed within the IDP framework

Proposed IDP title	Proposed measures
Improved school dental service	85 percent of 13 – 17 year olds use dental services each year by 2015.
Fewer unnecessary hospital admissions	5 percent nation-wide reduction in "Ambulatory Sensitive Admissions" by July 2011.
Better nutrition	(a) At least 74 percent of infants are fully and exclusively breastfed at six weeks by 2014, at least 57 percent at three months by 2012, and at least 27 percent at six months 2012. (b) At least 70 percent of adults eat three or more servings of vegetables per day, by 2014. (c) At least 62 percent of adults eat two or more servings of fruit per day, by 2014.
Better Mental Health services	At least 90 percent of long-term clients have up-to-date relapse prevention plans by July 2010.

Document 4

Appendix 2 List of DHBs who provided feedback on the draft Health Targets by 5pm 16 April 2009

DHB	Provided feedback
Auckland DHB	Yes (cancer only)
Bay of Plenty DHB	
Canterbury DHB	Yes
Capital and Coast DHB	Yes
Counties Manukau DHB	Yes
Hawke's Bay DHB	
Hutt Valley DHB	Yes
Lakes DHB	
MidCentral DHB	Yes
Nelson Marlborough DHB	Yes
Northland DHB	Yes
Otago DHB	
South Canterbury	
Southland DHB	
Tairawhiti DHB	
Taranaki DHB	Yes
Waikato DHB	Yes
Wairarapa DHB	Yes
Waitemata DHB	
West Coast DHB	
Whanganui DHB	

Document 4

Appendix 2 List of DHBs who provided feedback on the draft Health Targets by 5pm 16 April 2009

DHB	Provided feedback
Auckland DHB	Yes (cancer only)
Bay of Plenty DHB	
Canterbury DHB	Yes
Capital and Coast DHB	Yes
Counties Manukau DHB	Yes
Hawke's Bay DHB	
Hutt Valley DHB	Yes
Lakes DHB	
MidCentral DHB	Yes
Nelson Marlborough DHB	Yes
Northland DHB	Yes
Otago DHB	
South Canterbury	
Southland DHB	
Tairawhiti DHB	
Taranaki DHB	Yes
Waikato DHB	Yes
Wairarapa DHB	Yes
Waitemata DHB	
West Coast DHB	
Whanganui DHB	

Document 5

20 JUL 2009

MINISTRY OF HEALTH
MANATŪ HAUORA

Action required by:	24 July 2009	**Date sent to Minister:**	20 July 2009
Minister's reference/ OIA number:	N/A	**File number:**	AD62-09-5-3

Hon Tony Ryall, Minister of Health
Update on the Shorter Stays in Emergency Departments Health Target

Advice

1. This briefing provides an update on the Ministry of Health's (the Ministry's) activities with respect to the Health Target 'Shorter Stays in Emergency Departments: 95 percent of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours', which came into effect on 1 July 2009.

2. This briefing advises that the Ministry has agreed, through DHB's District Annual Plans (DAPs), to 16 DHBs working to achieve the 95 percent target in 2009/10 and a timeframe of up to three years for the remaining 5 DHBs due to their particular circumstances. It also seeks your approval for DHB results in respect to the ED Health Target to not be reported publicly until the second quarter of the 2009/10 year, to allow time for DHBs to refine the accuracy of their reporting systems.

Agreeing performance expectations with DHBs

3. When the ED Health Target was announced in May 2009 DHBs were advised that a date for achievement would be set once current performance data had been collected. This is because at that time the Ministry had little information about current DHB performance against the six hour target or their plans to improve ED services to inform the setting of realistic timeframes.

4. An initial focus of the ED work has therefore been on collecting and assessing DHB baseline data. All DHBs were sent a survey on 17 May 2009 requesting information about their current ED performance, initiatives, barriers and support needs. Concurrently, each DHB's DAP was reviewed for a demonstrated understanding of the potential solutions relating to ED overcrowding, the quality of plans in place to address these, and an appropriate structure to lead improvements. All of the DAPs contained a clear commitment to achieving the Health Target, however, the time needed to reach the 95 percent target varied.

5. The time to achieve the target is partly dependent on the current (starting) performance of the DHB but is significantly influenced by the projects and processes already underway. It is also important that genuine, 'whole of system' quality initiatives are embedded to improve the efficiency of the patient journey. Such initiatives should take time if they are to be done well and if temporary fixes and 'gaming' are to be avoided. For example, Counties Manukau DHB is advanced in this regard, while other DHBs, such Capital and Coast, Hutt Valley and Otago, have achieved less and therefore anticipate requiring a longer time to achieve the target.

6. Following negotiation, the Ministry has agreed through the DAPs to 16 DHBs working to achieve the target in 2009/10 and a timeframe of up to three years for the remaining five DHBs. This one to three year timeframe was advised in HR 20091053 'District Health Board 2009/10 District Annual Plans'. Even for those DHBs which have committed in their DAPs to achieving the target in 2009/10, once progress towards this has commenced and a greater understanding of the challenge has been gained, it may become appropriate to revise some to a slightly longer timeframe.

7. The table below provides a summary for each DHB of their baseline percentage of ED patients with a length of stay of less than 6 hours (provided in their survey response) and the targets and timeframes agreed to within their DAP for 2009/10.

DHB	Baseline	2009/10 target	Further information
Auckland	Adult ED 65% Children's ED 82%	95%	
Bay of Plenty	89.1%	95%	1 year timeframe: 85% in Q1, 87% in Q2, 92% in Q3 and 95% in Q4
Canterbury	90%	95%	
Capital & Coast	79.5%	90%	3 year timeframe: 90% in 2009/10, 92% in 2010/11 and 95% in 2011/12
Counties Manukau	82%	95%	
Hawke's Bay	80%	95%	
Hutt Valley	87%	90%	3 year timeframe: 90% in 2009/10, 92% in 2010/11 and 95% in 2011/12
Lakes	Rotorua ED Discharge home 99% Ward transfer 62% Taupo ED Discharge home 96% Ward transfer 66%	95%	
MidCentral	79.6%	95%	
Nelson Marlborough	98.1%	95%	
Northland	Whangarei 81.7% Kaitaia 98.9%	TBA	DHB committed to working towards 95% target. Will advise timeframes once baseline information has been analysed.
Otago	76%	80%	2 year timeframe: 80% in 2009/10 and 95% in 2010/11
South Canterbury	96.5%	95%	
Southland	93%	95%	
Tairawhiti	94.5%	95%	
Taranaki	Taranaki Base ED 85% Hawera ED 98%	95%	
Waikato	75%	95%	
Wairarapa	95%	95%	
Waitemata	65%	TBA	DHB committed to working towards 95% target. Will advise timeframes once baseline information has been analysed.
West Coast	99.3%	95%	
Whanganui	90%	95%	

Ministry's ED Work Programme

8. An ED project team has been established within the Ministry led by Professor Mike Ardagh, National Clinical Director of ED Services. An ED Advisory Group has also been established to advise the Ministry on aspects of the ED work programme and to provide clinical leadership at both the national and DHB level. The first meeting of the Advisory Group took place on 25 June 2009 and will next meet in early September. The membership of the Advisory Group is provided in Appendix 1.

9. The ED team has been developing a work programme and structures to support DHBs to achieve the Target. Work underway at present includes:

- Organising visits over the next few months to six DHBs of differing sizes and performance to gain a more in-depth assessment of their ED systems and either identify initiatives that are working well and can be disseminated to other DHBs (Auckland, Taranaki and Wairarapa) or areas requiring improvement (Capital and Coast, Otago and Whanganui). Further visits to the remaining DHBs will occur throughout the financial year.
- Arranging to meet with national DHB groups, such as Chief Executives, Chief Operating Officers and Chief Medical Officers, in recognition that responding to the Target will require a whole-of-system and whole-of-hospital approach which senior DHB management are best placed to lead.

- Establishing and communicating to DHBs the Ministry's expectations, such as the development of an ED Action Plan with initiatives across the whole system, and the quality measures to be collected and monitored within the DHB.
- Linking with other work programmes in recognition of the whole of system nature of the Target. Where possible these existing programmes will be used to implement changes that support improvements to ED services. For example, the Primary Health Care Implementation programme, through increasing and promoting the services available in the primary health care sector, will provide patients with an alternative to attending EDs and provides EDs with a potential outlet to refer lower acuity patients. Programmes relating to chronic disease will reduce the number and severity of admissions to hospital of people suffering from chronic disease and other avoidable hospital admissions which will ease the pressure on EDs.
- Developing a web presence to promote the ED Health Target, engage ED clinical networks and act as a home for communication/discussion and tools/resources.

Reporting

10. DHBs will report data against the Target for each relevant ED facility quarterly during 2009/10. In the first and fourth quarters DHBs will also provide narrative comment on the quality of their data, steps taken to meet the target and improve the quality of ED care, and any difficulties encountered with implementation of the target.

11. From the third quarter, any ED that does not meet the agreed targets will submit a report to the Ministry explaining progress to-date, reasons for failure to achieve the target, and actions to address these reasons.

12. The Ministry recommends that DHB results with respect to the ED Health Target not be reported publicly until the second quarter of 2009/10 to allow time for DHBs to refine the accuracy of their reporting systems.

Recommendations

The Ministry recommends that you:

a) **Note:** when the ED Health Target was announced in May 2009 DHBs were advised that a date for achievement would be set once current performance data had been collected. Yes / ~~No~~

b) **Note:** the Ministry has agreed through the DAPs to 16 DHBs working to achieve the target in 2009/10 and a timeframe of up to three years for the remaining five DHBs. (Review next DAP → shorter) Yes / ~~No~~

c) **Agree:** that DHB results with respect to the ED Health Target not be reported publicly until the second quarter of 2009/10 to allow time for DHBs to refine the accuracy of their reporting systems. ~~Yes / No~~ NO.

- Effort should go into poor performers first.
- Needs stronger engagement with clinical staff in wards.

Margie Apa
Deputy Director-General
Sector Capability and Innovation Directorate

Ryan

MINISTER'S SIGNATURE:

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Appendix 1: Membership of the Emergency Department Advisory Group

Who	Role
Mike Ardagh	National Clinical Director ED Programme (Chair)
Tim Parke	ED Clinician (FACEM) / Auckland DHB
Peter Freeman	ED Clinician (FACEM) / Capital & Coast DHB
Tom Morton	ED Clinician (FACEM) / Nelson Marlborough DHB
Justin Moore	ED Nursing (CENNZ) / Canterbury DHB
Carrie Naylor-Williams	ED Nursing (CENNZ) / MidCentral DHB
Michael Geraghty	ED Nursing (CENNZ) / Auckland DHB
Mike Hunter	Acute Care Networks (ECCT) / Otago DHB
Geraint Martin	CEO, Counties Manukau DHB
Tracey Adamson	CEO, Wairarapa DHB
Carolyn Gullery	General Manager Planning & Funding, Canterbury DHB
Joy Farley	General Manager Hospital Services, Taranaki DHB
Jim Primrose	Chief Advisor, Primary Health Care, Ministry of Health
Margie Apa	Deputy Director-General, Sector Capability and Innovation Directorate, Ministry of Health
Gary Tonkin	Project Manager, ED Programme, Ministry of Health (support)
Analyst	Ministry of Health (support)

FACEM = Fellow of the Australasian College of Emergency Medicine
CENNZ = College of Emergency Nurses New Zealand
ECCT = Emergency Care Co-ordination Team

Document 6

Health Report Number 20091587

Action required by:		**Date sent to Minister:**	
Minister's reference/ OIA number:		**File number:**	HC06-01-1

Hon Tony Ryall
Health Targets—2008/09 results and 2009/10 publication

1. This paper briefs you on:
   - the final results of sector performance against Health Targets for 2008/09, and
   - seeks your approval for the web publication of a summary document on the recently introduced 2009/10 Health Targets.

2008/09 Results

2. The Ministry of Health (Ministry) Health Targets Steering Group has reviewed the results for the year, and it has agreed that the year-end results will be published on the Ministry's website, under the Health Targets permanent section. A similar structure to that used in previous quarters will be applied, with no public launch of the results planned, as approved in HR No 20090224.
3. The New Zealand health system has continued to make progress across the Health Target areas in 2008/09 (see Appendix 1 for more information). Overall the most positive result was in the Electives Health Target, with a record increase in elective surgery. The poorest result was in the immunisation target, with only four DHBs achieving their individual targets. However, all DHBs now have active immunisation steering groups in place, and new initiatives are being developed and shared with other DHBs.

4. National Achievements

	Health Target	Goal	Achievements
1	Improving Childhood Immunisation Coverage	95 percent of two-year-olds are fully immunised by 2012	In July 2009 coverage reached 80 percent of the enrolled NIR population. This is an increase of 3 percent since July 2008 and 12 percent since the immunisation target has been measured.
2	Improving Oral Health	85 percent of adolescents reached by oral health services	The 2008/09 national target has been substantially met. An additional 5,864 adolescents accessed dental services in 2008 than the previous year—173,431 young people or 60.5 percent of eligible adolescents.
3	Improving Elective Services[1]	• DHBs deliver an agreed increase in the level of elective discharges • All DHBs maintain compliance with Elective Services Patient Flow Indicators (ESPI)	An excellent result was achieved in the target to deliver additional discharges; achievement levels in Elective Service Patient Flow Indicators (ESPIs) showed significant improvement compared with 2007/08: • ESPIs: 16 DHBs received achieved or outstanding ratings • Discharge Volumes: DHBs achieved a 16 percent increase in elective discharges, representing 20,075 additional discharges over the agreed base.

[1] The elective services discharge component of the 2008/09 Health Target differs from the publicly reported number of elective surgical discharges. The 2008/09 Health Target includes cardiology and dental discharges and achievement is reported against an agreed base level of discharges rather than the number of discharges delivered in the previous year. The number of elective surgical discharges delivered in 2008/09 was 129,769 which was 11,805 (10 percent) more than delivered in 2007/08

	Health Target	Goal	Achievements
4	Reducing Cancer Waiting Times	100 percent of patients wait less than six weeks from referral to treatment	In the month of June 2009, 674 people, or 98 percent of all patients (excluding those delayed for reasons not related to capacity), started treatment within six weeks—77 percent of them within four weeks. This was the best performance of any quarter in 2008/09.
5	Reducing Ambulatory-Sensitive (Avoidable) Hospital Admissions	Lower overall avoidable admissions and reduce variation amongst DHBs and population groups	In 2008/09 there were 461 fewer Ambulatory Sensitive Admissions compared with 2007/08. This target area has 147 sub-targets, of which 86 percent (126) were achieved.
6	Improving Diabetes Services	• increased percentage of the eligible adult population will have had their CVD risk assessed in the previous five years	The national target for cardiovascular disease was a 2 percent increase in the proportion of eligible people who had received the laboratory tests for cardiovascular risk assessment in the previous five years. This national target was exceeded for Māori (2.5 percent improvement during 2008/9), Pacific (4.0 percent), and all New Zealanders (2.3 percent).
		• increased percentage of people with diabetes will attend free annual checks	The number of people with diabetes who participated in the Get Checked quality improvement programme increased from 88,780 in 2007/08 to 100,249 in 2008/09. This exceeded the combined national health target by almost 2,000 extra people. An equally impressive result is that the proportion of people with diagnosed diabetes accessing Get Checked is now greatest in Pacific (61 percent), then Māori (56 percent), then people of other ethnicities (53 percent).
		• increased percentage of people with diabetes will have satisfactory or better diabetes management.	In the same period, the target for improving the effectiveness of diabetes care improved—from 71 percent to 72 percent of people who had "satisfactory or better" diabetes control. The national average DHB target is 73 percent.
7	Improving Mental Health Services	Care for long-term mental health clients is well managed	Nationally, the rate of long term clients with relapse prevention plans has increased steadily since the introduction of this Health Target. At the end of 2008/09, 88 percent of adult clients had relapse prevention plans, up from 60 percent since the inception of the mental health target in 2007/08. While the overall results are pleasing, effort will still be required to maintain and improve on these results.
8	Improving Nutrition, Increasing Physical Activity, and Reducing Obesity	More people at recommended levels of healthy eating and physical exercise	A national survey by Research NZ indicates the following improvements in breastfeeding rates compared to the national targets—as at March 2009: • Six week exclusive and fully breastfed rate was 72 percent compared to the national target of 7 4percent • Three month exclusive and fully breastfed rate was 69 percent compared to the national target of 57 percent • Six month exclusive and fully breastfed rate was 31 percent compared to the national target of 27 percent.
9	Reducing the Harm Caused by Tobacco	• Reduce the prevalence of exposure of non-smokers to second-hand smoke (SHS) inside the home to less than 5 percent and achieve a reduction in the prevalence of exposure of non-smokers to SHS inside the homes for Māori and for Pacific that is greater than for European	The overall age-standardised rate of exposure of non-smokers to second-hand smoke (SHS) inside the home dropped from 8.4 percent in 2007 to 7.1 percent in 2008. While this is not as low as the 5 percent target, it continues a strong ongoing downward trend from the 2006 figure of 10.7 percent. Importantly, there was a greater reduction in exposure to SHS inside the homes from 2007 to 2008 for both Māori and Pacific peoples than for European/Others. The drop for Māori and Pacific was also greater than for the Total NZ, both in relative and absolute terms.
		• Increase the proportion of 'never smokers' among Year 10 students by at least 3 percent	The overall increase in the proportion of 'never smokers' among Year 10 students increased by 3.3 percent. This is greater than the 3 percent target set for 2008/09. There was a 4.3 percent increase for boys and 2.4 percent increase for girls.
10	Reducing the Percentage of the Health Budget Spent on the Ministry of Health	Increase the proportion of health budget spent on health care – reduce the Ministry's expenditure to 1.65 percent by 2009/10	The percentage of Vote: Health as at June 2009 (based on actual expenditure) spent on the Ministry of Health Departmental operations is 1.81 percent against the three year target of 1.65 percent. The target was due to be met at year 2010; the Ministry continues to manage operating costs to ensure ongoing cost efficiencies are achieved.

5. A comprehensive report, including graphical information and a qualitative assessment made by the each of the targets' champions, will be available on the Ministry's webpage, *www.moh.govt.nz/healthtargets*. A hard copy summary can be provided if you wish to see it.

2009/10 Targets

6. Attached as Appendix 2 is a copy of the **2009/10 Health Targets Summary Report**. The purpose of this document is to provide a resource to DHBs and the general public. It is intended to be used as a reference document providing base information and context for the six targets, including how they will be measured.
7. This report is designed as a brief factual introduction to the 2009/10 targets, and will be published on the Health Targets webpage only as an electronic document (pdf). No hardcopy production is planned. This document includes a summary table with the targets that individual DHBs have agreed in their District Annual Plans (DAP).
8. The Ministry has drafted a ministerial introduction, for your consideration, based on priorities and strategic orientations outlined by you in the Ministry Statement of Intent (SOI). Following approval, the document will be formatted to Ministry standards and submitted for your review before placing it on the website.

Appendices

- Appendix 1: Summary Table of 2008/09 DHB-related Health Targets Results
- Appendix 2: 2009/10 Health Targets Summary Report

Recommendations

The Ministry recommends that you:

a) **Agree** that Health Targets' 2008/09 results will be published on the Ministry of Health's website, following confirmation from your office that you have read this report. Yes / ~~No~~

b) **Agree** to the content of the draft introduction for the Health Targets 2009/10 Summary Report that is based on the statements you made in the SOI. Yes / ~~No~~ As amended

c) **Note** the Health Targets 2009/10 Summary Report will be sent to you for approval to publish following the completion of the design and layout of the document. Yes / ~~No~~

d) **Note** it is proposed that the Health Targets 2009/10 Summary Report will be published on the health targets webpage in pdf format only. Yes / ~~No~~ OK - saves money compared to previous years.

Les Stephens
Manager, Performance
Sector Accountability & Funding

Ryan

MINISTER'S SIGNATURE:
DATE: 27.10.9.

Ministry Contact 1:	
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Appendix 1—DHB Health Targets 08/09 results Summary Table

	Immunisation		Oral Health		Cancer		Elective Volumes		Reducing Ambulatory-sensitive (Avoidable) Hospital Admissions (1)																Improving Diabetes Services																						Improving Mental Health Services	
									Maori		ASH0-74 Pacific		Other		Maori		ASH0-4 Pacific		Other		Maori		ASH45-64 Pacific		Other		DiabetesChecks								DiabetesManagement								DiabetesCVDLipids								Mental Health	
																									Maori		Pacific		Other		Total		Maori		Pacific		Other		Total		Maori		Pacific		Other		Total			
	T	R	T	R	T	R	T	R	T	R	T	R	T	R	T	R	T	R	T	R	T	R	T	R	T	R	T	R	T	R	T	R	T	R	T	R	T	R	T	R	T	R	T	R	T	R	T	R	T	R
Northland	80%	69%	50%	40%	100%	100%	8%	26%	100	108			96	94	118	109			96	86	96	111			96	89	60%	60%		60%	46%	60%	51%	70%	59%			80%	81%	76%	72%	65%	66%			76%	76%	73%	73%	90%	92%
Waitemata	85%	85%	56%	56%	100%	100%	9%	18%	110	113	107	110	108	102	101	97	107	101	108	73	118	118	107	108	108	115	43%	43%	42%	39%	40%	37%	41%	38%	71%	67%	61%	59%	84%	82%	80%	78%	69%	69%	69%	72%	78%	79%	77%	78%	90%	91%
Auckland	80%	80%	52%	62%	100%	100%	10%	27%	100	109	98	109	95	91	95	99	98	96	95	71	116	128	98	107	95	102	50%	49%	50%	60%	55%	49%	55%	52%	70%	62%	70%	60%	83%	79%	79%	72%	69%	70%	69%	72%	76%	77%	75%	76%	90%	86%
Counties Manukau	80%	78%	57%	56%	100%	100%	10%	19%	111	112	105	110	101	106	95	94	105	102	101	90	122	134	105	111	101	114	63%	80%	65%	76%	65%	61%	65%	69%	60%	54%	52%	48%	80%	72%	68%	60%	70%	71%	70%	71%	80%	80%	76%	77%	90%	96%
Waikato	79%	76%	68%	61%	100%	100%	10%	14%	95	89	95	61	95	85	95	63	95	57	95	78	95	108	95	58	95	82	40%	44%	41%	46%	47%	58%	45%	55%	62%	62%	62%	55%	77%	77%	74%	74%	57%	58%	53%	55%	70%	72%	68%	69%	90%	90%
Lakes	78%	66%	50%	48%	100%	100%	10%	16%	105	123			111	113	116	144			111	133	98	121			111	107	55%	49%		60%	61%	58%	56%	60%	57%			75%	63%	69%	61%	59%	58%			74%	73%	70%	68%	90%	80%
Bay of Plenty	78%	69%	68%	56%	100%	100%	10%	10%	101	106			98	95	103	112			98	117	98	100			98	89	51%	81%		69%	61%	64%	65%	70%	72%			80%	87%	78%	82%	51%	47%			64%	60%	61%	57%	95%	89%
Tairawhiti	82%	73%	66%	63%	100%	100%	11%	21%	111	121			112	110	155	110			112	114	95	130			112	98	58%	63%		62%	59%	61%	61%	62%	63%			75%	76%	70%	69%	65%	64%			74%	74%	69%	69%	100%	100%
Hawke's Bay	85%	89%	70%	74%	100%	82%	10%	2%	98	99			97	94	100	106			97	87	95	92			97	96	65%	59%		65%	64%	65%	63%	70%	66%			70%	81%	70%	76%	65%	64%			79%	77%	77%	76%	90%	ND
Taranaki	87%	79%	62%	70%	100%	91%	10%	17%	95	98			95	93	95	96			95	84	95	94			95	94	59%	65%		69%	83%	67%	80%	74%	66%			85%	82%	83%	80%	49%	48%			69%	67%	65%	63%	90%	95%
MidCentral	82%	77%	80%	79%	100%	74%	10%	11%	95	76			95	90	95	72			95	90	95	63			95	88	51%	51%		49%	65%	49%	62%	65%	60%			76%	76%	74%	73%	69%	69%			82%	81%	79%	78%	90%	94%
Whanganui	88%	84%	66%	58%	100%	100%	10%	-8%	116	123			111	109	145	161			111	102	95	108			111	105	60%	56%		80%	63%	74%	60%	70%	53%			82%	72%	81%	68%	56%	57%			71%	73%	69%	71%	90%	92%
Capital & Coast	85%	87%	43%	39%	100%	100%	10%	11%	94	90	86	81	90	82	94	94	86	76	90	87	102	93	86	72	90	80	42%	43%	47%	54%	44%	49%	45%	49%	65%	63%	60%	49%	80%	78%	76%	72%	62%	64%	60%	62%	74%	74%	71%	72%	95%	86%
Hutt Valley	87%	85%	66%	52%	100%	100%	10%	16%	116	111	100	109	115	109	127	121	100	128	115	131	106	90	100	88	115	106	41%	46%	51%	60%	52%	67%	50%	63%	57%	60%	50%	50%	79%	78%	72%	72%	66%	66%	69%	69%	77%	77%	76%	75%	99%	39%
Wairarapa	89%	85%	81%	74%	100%	80%	10%	62%	116	165			115	144	115	136			115	103	118	157			115	135	80%	73%			80%	83%	78%	75%	72%	63%			75%	79%	75%	75%	69%	70%			77%	78%	76%	77%	98%	86%
Nelson Marlborough	84%	81%	74%	75%	100%	100%	10%	27%	95	95			98	103	95	116			98	109	95	85			98	103	47%	46%			53%	57%	52%	55%	70%	41%			80%	53%	79%	50%	38%	33%			48%	42%	47%	42%	95%	95%
West Coast	91%	80%	75%	70%	100%	100%	10%	6%	106	88			95	89	116	65			95	59	107	92			95	90	70%	50%			70%	53%	70%	52%	80%	73%			80%	82%	80%	82%	63%	62%			74%	73%	73%	72%	98%	100%
Canterbury	88%	86%	70%	66%	81%	100%	10%	15%	100	82	100	108	103	98	104	95	100	98	103	106	100	89	100	102	103	94	33%	31%	26%	35%	44%	38%	43%	38%	70%	67%	56%	55%	78%	80%	77%	78%	57%	58%	55%	55%	68%	69%	68%	68%	95%	92%
South Canterbury	91%	89%	88%	84%	100%	100%	10%	28%	95	108			110	119	95	120			110	101	95	81			110	126	53%	53%			64%	73%	64%	71%	72%	67%			82%	82%	81%	81%	57%	57%			68%	67%	67%	67%	90%	96%
Otago	91%	90%	85%	83%	100%	100%	5%	0%	95	72			95	96	95	80			95	99	95	59			95	103	38%	31%			59%	56%	55%	55%	69%	65%			75%	80%	74%	79%	62%	61%			74%	74%	73%	73%	90%	83%
Southland	94%	91%	80%	65%	100%	100%	8%	18%	95	102			103	113	95	118			103	126	95	78			103	106	49%	41%			52%	57%	51%	55%	72%	68%			76%	84%	75%	83%	51%	53%			64%	67%	63%	65%	90%	99%

Keys:

Immunisation: Percentage of two-year-olds fully immunised
Oral Health: Percentage of Adolescent Oral Health utilisation
Cancer: Proportion of patients in category A, B, or C waiting less than 6 weeks to start radiation treatment
Ambulatory-sensitive Hospital Admissions (ASH): Indirectly Standardised Discharge Ratios (ISDRs)
Improving Diabetes Services : Percentage of people accessing free annual checks
Percentage of people with good diabetes management
Percentage of people with CVD assessment
Improving Mental Health Services: Percentage of long-term clients with up-to-date relapse prevention plans with CVD assessment

T Target
R Result

Target achieved
Target not achieved

(1) Note: No data available for Hawke's Bay---problems with Patient Management System

Appendix 2: Summary report on the Health Targets for 2009/10

From the Minister of Health

Draft Only

The Government is committed to ensuring that it has an effective and efficient health and disability sector that provides 'better, sooner, more convenient' services to all New Zealanders.

Improving performance across the sector is fundamental to this goal and I have identified six target areas to focus progress on. These targets are also indicators of overall system performance.

For 2009/10 the six health targets are

- Shorter stays in emergency departments
- Improved access to elective surgery
- Shorter waits for cancer treatment
- Increased immunisation
- Better help for smokers to quit
- Better diabetes and cardiovascular services.

The first three focus attention on the urgent issue of excessive patient waiting times in public hospitals.

The last three focus on early intervention to prevent ill health, investing in the health of our children, and effective prevention through primary health care services.

Focusing on the six health targets will not only impact on the chosen areas, but will also relieve pressure and lift performance across the health sector as a whole.

These six health targets will ensure monitoring and reporting functions are minimised, leaving service providers with time and effort to put into improving performance and providing quality services on time and where patients need them.

Progress will be reviewed quarterly and reported on the Ministry of Health website. The health targets will be reassessed annually to ensure they are relevant and align with the health priorities of the time.

I look forward to following progress and being able to report back the improvements achieved to the New Zealand public.

From the Director-General of Health

The challenge for the health and disability sector is to continue improving the performance and sustainability of the health and disability system against a background of growing community expectation and increasing financial and structural pressures.

Our role as the Ministry of Health is to provide leadership and ensure services are planned, funded and delivered in a way that improves productivity and cost effectiveness in an increasingly resource constrained environment.

Delivering the priorities defined through the Health Targets is a collective responsibility of the Ministry of Health (Ministry) and District Health Boards (DHBs).

Each DHB sets objectives as part of its District Annual Plan (DAP) and to help them meet the '2009/10 Health Targets', the Ministry has appointed a 'champion' for each target to work with and provide support to the DHBs, help and advise those who are struggling to meet their targets, and monitor and report on progress.

By the health sector working together it will make each part of the system stronger and make it easier to deliver excellent health services quickly and efficiently.

By paying close attention to the issue of access to elective surgery, patient waiting times, early intervention to prevent ill health, investing in the health of our children, and effective prevention through excellent primary health care services, we will make a significant impact on the health of all New Zealanders.

Through co-operation, sharing best practice and striving always to do the best, I am confident we will see a marked improvement in the delivery of health services in 2009/2010.

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2009/10 Health Targets

Health Target	Indicators
Shorter stays in Emergency Departments	95 percent of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours.
Improved access to elective surgery	The volume of elective surgery will be increased by an average 4000 discharges per year (compared with the previous average increase of 1400 per year).
Shorter waits for cancer treatment	Everyone needing radiation treatment will have this within six weeks of decision to treat by the end of July 2010 and within four weeks by December 2010.
Increased immunisation	85 percent of two year olds will be fully immunised by July 2010; 90 percent by July 2011; and 95 percent by July 2012.
Better help for smokers to quit	80 percent of hospitalised smokers will be provided with advice and help to quit by July 2010; 90 percent by July 2011; and 95 percent by July 2012. Similar targets for primary care will be introduced from July 2010 or earlier, through the PHO Performance Programme.
Better diabetes and cardiovascular services	(a) an increased percent of the eligible adult population will have had their Cardio-Vascular Disease (CVD) risk assessed in the last five years (b) an increased percent of people with diabetes will attend free annual checks (c) an increased percent of people with diabetes will have satisfactory or better diabetes management

Individual Agreed DHB 2009/10 Health Targets

The following table contains the health targets each DHB has agreed to in their 2009/10 District Annual Plans. Where appropriate the table includes targets by ethnicity.

Please note that some DHBs have provided targets for the Pacific population. However, only DHBs with significant Pacific populations (Waitemata, Auckland, Counties Manukau, Waikato, Capital & Coast, Hutt Valley, and Canterbury DHBs) have been included in the table.

Targets by DHB

	Emergency Department stay times	*Electives Discharges*	*Cancer Waiting times*	*Immunisation Children*			*Tobacco hospitalised smokers*	*Diabetes and Cardiovascular Disease (CVD)*											
								CVD Lipids				*Diabetes Free Checks*				*Diabetes Management*			
				Māori	*Pacific*	*Total*		*Māori*	*Pacific*	*Other*	*Total*	*Māori*	*Pacific*	*Other*	*Total*	*Māori*	*Pacific*	*Other*	*Total*
Northland	91%	100%	100%	85%	NA	85%	80%	66.9%	NA	77.8%	74.7%	60.0%	NA	60.0%	60.0%	70.0%	NA	80.0%	76.0%
Waitemata	79%	100%	100%	85%	85%	85%	80%	71.0%	72.0%	80.4%	79.2%	55.0%	52.0%	47.0%	48.0%	56.0%	61.0%	83.0%	78.0%
Auckland	95%	100%	100%	75%	83%	85%	80%	71.0%	71.9%	78.8%	77.0%	46.0%	58.0%	49.0%	52.0%	67.0%	68.0%	83.0%	77.0%
Counties Manukau	95%	100%	100%	85%	85%	85%	80%	72.3%	73.0%	80.5%	78.0%	67.0%	75.0%	65.0%	68.0%	54.0%	48.0%	71.0%	60.0%
Waikato	95%	100%	100%	66%	74%	81%	80%	63.0%	58.0%	75.0%	72.0%	42.0%	52.0%	56.0%	52.0%	66.0%	66.0%	78.0%	76.0%
Lakes	95%	100%	100%	71%	NA	85%	80%	59.0%	NA	75.0%	70.0%	60.0%	NA	62.0%	60.0%	65.0%	NA	75.0%	71.0%
Bay of Plenty	95%	100%	100%	65%	NA	78%	80%	53.0%	NA	66.0%	63.0%	54.0%	NA	72.0%	67.0%	69.0%	NA	84.0%	82.0%
Tairawhiti	95%	100%	100%	80%	NA	80%	80%	65.8%	NA	75.0%	70.6%	60.0%	NA	60.0%	60.0%	65.0%	NA	84.0%	68.0%
Hawke's Bay	95%	100%	100%	85%	NA	87%	80%	67.7%	NA	80.5%	78.0%	65.0%	NA	65.0%	65.0%	72.0%	NA	80.0%	78.0%
Taranaki	95%	100%	100%	79%	NA	79%	80%	49.2%	NA	69.0%	64.8%	59.0%	NA	71.0%	69.0%	74.0%	NA	85.0%	83.0%
MidCentral	95%	100%	100%	85%	NA	85%	80%	70.3%	NA	81.1%	78.5%	54.0%	NA	63.0%	62.0%	70.0%	NA	79.0%	78.0%
Whanganui	95%	100%	100%	88%	NA	89%	80%	58.7%	NA	74.0%	72.2%	60.0%	NA	66.0%	65.0%	60.0%	84.0%	82.0%	76.0%
Capital & Coast	90%	100%	100%	80%	83%	88%	80%	63.6%	61.9%	76.1%	72.6%	45.0%	54.0%	53.0%	52.0%	64.0%	54.0%	78.0%	74.0%
Hutt Valley	90%	100%	100%	87%	87%	87%	80%	67.0%	70.0%	78.0%	76.0%	55.0%	63.0%	64.0%	63.0%	59.0%	52.0%	81.0%	74.0%
Wairarapa	95%	100%	100%	85%	NA	85%	80%	73.0%	NA	78.0%	77.0%	72.0%	NA	77.0%	75.0%	72.0%	NA	77.0%	75.0%
Nelson Marlborough	95%	100%	100%	79%	NA	81%	80%	(1)	NA	(1)	(1)	52.0%	NA	76.0%	72.0%	72.0%	NA	82.0%	79.0%
West Coast	95%	100%	100%	85%	NA	91%	80%	62.8%	NA	72.5%	71.8%	65.0%	NA	65.0%	65.0%	80.0%	NA	80.0%	80.0%
Canterbury	95%	100%	100%	85%	85%	85%	80%	57.1%	55.1%	68.9%	68.0%	33.0%	26.0%	44.0%	43.0%	70.0%	56.0%	78.0%	77.0%
South Canterbury	95%	100%	100%	92%	NA	92%	80%	58.2%	NA	69.0%	68.5%	55.0%	NA	67.0%	66.0%	75.0%	NA	83.0%	83.0%
Otago	80%	100%	100%	92%	NA	92%	80%	63.0%	NA	75.0%	75.0%	38.0%	NA	62.0%	60.0%	71.0%	NA	82.0%	81.0%
Southland	95%	100%	100%	91%	NA	93%	80%	55.0%	NA	68.0%	67.0%	46.0%	NA	62.0%	60.0%	72.0%	NA	88.0%	86.0%

Source: DAPs advice to the Minister

Keys:

(1) *Data issues, target will be set once data available.*

NA *DHBs with low Pacific ethnicity population.*

Health Target 1: Shorter stays in emergency departments

Target Indicator
95 percent of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours.

Target Champion - Professor Mike Ardagh, National Clinical Director of Emergency Department Services.

Why is this target area important?
ED length of stay is an important measure of the quality of acute (emergency and urgent) care in our public hospitals, because:

- EDs are designed to provide urgent (acute) health care; the timeliness of treatment delivery (and any time spent waiting) is by definition important for patients
- Long stays in emergency departments are linked to overcrowding of the ED
- The medical and nursing literature has linked both long stays and overcrowding in EDs to negative clinical outcomes for patients such as increased mortality and longer inpatient lengths of stay
- Overcrowding can also lead to compromised standards of privacy and dignity for patients, for instance, through the use of corridor trolleys to house patients.

How we will measure progress
This is the first year the 'Shorter stays in emergency departments' health target will be measured.

All DHBs have committed to reaching the 95 percent target, although the time taken to reach the target will vary from DHB to DHB as agreed through DHB District's Annual Plans (DAP).

DHBs will report against the target by providing information on the number of patients presenting to each ED and their length of stay. This is measured by the time from when a patient presents to the time the patient is admitted, discharged or transferred.

The Ministry will work with the sector to look at a whole of system approach and good local clinical leadership which improves the quality of care and outcomes for the patient. This will include ensuring that other performance measures are being monitored at the DHB level to improve quality and steps are being taken to meet the health target and improve the quality of ED care.

Any ED that does not meet the agreed targets will submit a report to the Ministry explaining progress to date, reasons for failure to achieve the target and actions to address these reasons.

Current status
All DHBs have committed to reaching the 95 percent target, although the time taken to reach the target will vary from DHB to DHB. The time to achieve the target is partly dependent on the current (starting) performance of the DHB but is significantly influenced by the projects and processes already underway. Following negotiation, the Ministry has agreed through the DAP to 16 DHBs working to achieve the target in 2009/10 and longer timeframes for the remaining five DHBs. These timeframes will be revisited during the 2010/11 DHB DAP process.

Health Target 2: Improved access to elective surgery

Target Indicator
The volume of elective surgery will be increased by an average 4000 discharges per year (compared with the previous average increase of 1400 per year).

Target Champion - Kieran McCann, Manager, Elective Services.

Why is this target area important?
The Government wants the public health system to deliver better, sooner, more convenient healthcare for all New Zealanders.

Over the period 2000/01 to 2007/08 the number of publicly funded elective surgical discharges rose by an average of 1,432 discharges per annum. The growth in elective surgical discharges did not keep up with population growth over this period. There is a need to increase the rate of growth of elective surgery. This in turn will increase access and should achieve genuine reductions in waiting times for patients.

How we currently deliver elective services
The key principles underlying the delivery of elective services in New Zealand are clarity, timeliness and fairness:

- Clarity is about whether patients know whether or not they will receive publicly funded services
- Timeliness is about patients who are given a commitment to treatment, receiving that treatment in a timely manner.
- Fairness is about ensuring that the resources available are directed to those most in need.

Ministry expectations regarding the delivery of elective services are that:

- All patients referred to hospital by their GP who can be seen within the available resources are seen for a first specialist assessment within six months.
- All patients assigned a priority by a specialist are managed in accordance with that priority (relative to the priorities assigned to other patients managed by that service).
- All patients given a commitment to treatment should receive that treatment within a timeframe consistent with their relative priority and within a maximum of six months.

It should be noted that for this health target the definition of elective surgery excludes dental and cardiology services.

Current status
In 2008/09 DHBs delivered over 129,000 elective surgical discharges. This was an outstanding achievement and represented an increase of 10percent over the number of discharges delivered in 2007/08.

The Ministry has been considering the minimum requirements for the national and individual DHB 'Improved access to elective surgery' health targets in 2009/10. One of the important elements of the future success of the health target is that it provides a pathway towards equitable investment in, and access to, elective surgery.

What are the areas of focus and development for this target?

- Increasing regional collaboration.
- Fostering clinical leadership and clinical networks to improve quality and productivity.
- Investing in new dedicated elective surgery theatres to provide capacity to deliver more elective services.
- Increasing hospital productivity to ensure that hospitals work in the most effective way possible.
- Increasing the devolution of services to primary care so that services are provided in the most appropriate and convenient locations for patients.
- Making smarter use of the private sector to support the delivery of publicly funded services.

How we will measure progress

DHBs will set a target number of publicly funded, case mix included, elective discharges in a surgical specialty (defined by surgical purchase units excluding dental) for people living within the DHB region. Performance will be measured using data from the National Minimum Data Set (NMDS[2]).

[2] The NMDS is a national collection of public and private hospital discharge information for inpatients and day patients.

Health Target 3: Shorter waits for cancer treatment

Target Indicator
Everyone needing radiation treatment will have this within six weeks by the end of July 2010 and within four weeks by December 2010.

Target Champion - Dr John Childs, National Clinical Director, Cancer Programme.

Why is this target area important?
Specialist cancer treatment and symptom control is essential in reducing the impact of cancer. Development of indicators that mark quality cancer treatment is, however, restricted by the lack of routinely collected information on common treatment.

In the interim, waiting times for radiation oncology treatment have been chosen as a representative indicator of specialist treatment, as it has been a service area with waiting time issues for patients. This is justifiable, because radiotherapy is of proven effectiveness in reducing the impact of a range of cancers, and delay to radiotherapy is likely to lead to poorer outcomes from treatment.

A six week wait time is currently targeted. The wait time will move to four weeks by December 2010.

How we currently provide radiation treatment for cancer
Radiation treatment is provided using machines called linear accelerators which are located in six public and one private cancer centre throughout New Zealand (a second private cancer centre will be providing cancer treatment in 2010).

Current status
Patients requiring radiotherapy are prioritised into categories (A, B, C and D), according to the urgency of their treatment. All six DHB cancer centres have been reporting radiation treatment waiting times regularly since March 2003. This includes the number of patients starting radiation treatment within defined time periods by prioritisation category.

In the month of June 2009, 674 people, or 98 percent of all patients (excluding those delayed for reasons not related to capacity), started treatment within six weeks—77 percent of them within four weeks. This was the best performance of any quarter in 2008/09.

The Ministry is pleased with this level of performance, but this will need to be sustained, and DHBs will need to work together to ensure ongoing process improvement, appropriate resource planning, and early identification of potential problems.

What are the areas of focus and development for this target?
The focus for this target is ensuring that people requiring radiotherapy receive it within six weeks, except for Category D, from decision-to-treat to treatment.

While this target is aimed at improving radiation treatment capacity, it is also a starting point for driving improvements for access to surgery and chemotherapy.

How we will measure progress

Currently, the Ministry collects information from all DHBs monthly on the length of waiting times for radiotherapy. This is available on the Ministry website: *www.moh.govt.nz/moh.nsf/indexmh/cancercontrol-treatment-radiation*

Reports will be collated on a quarterly basis and made available publicly.

Health Target 4: Increased immunisation

Target Indicator
85 percent of two year olds will be fully immunised by July 2010; 90 percent by July 2011; and 95 percent by July 2012.

Target Champion - Dr Pat Tuohy, Chief Advisor, Child & Youth Health

Why is this target area important?
The national immunisation goal is 95 percent of children fully immunised at two years of age by ethnicity.

Immunisation can prevent a number of diseases and is a very cost-effective health intervention. Immunisation provides not only individual protection for some diseases but also population-wide protection by reducing the incidence of diseases and preventing them spreading to vulnerable people. Some of these population-wide benefits only arise with high immunisation rates, depending on the infectiousness of the disease and the effectiveness of the vaccine. New Zealand's current immunisation rates are low by international standards and are not sufficient to prevent or reduce the impact of vaccine preventable diseases such as measles and pertussis (whooping cough).

Increasing coverage for 2-year olds will require improvements in the whole immunisation system that should improve other measures as well.

Coverage for 2-year olds tells us whether children have received the full series of infant immunisations, when they are most vulnerable, and also tells us which children are not being reached by our immunisation system. It is a commonly-used measure internationally. It is still important that DHBs measure coverage at other milestone ages as this will provide more information about the immunisation system.

How we provide immunisation services
Services that support childhood immunisation in most DHBs include:

- General practice in primary care services.
- Outreach immunisation services through other providers including Māori or Pacific health providers. These services find children who are overdue for their vaccination and deliver immunisations or refer children to primary care services.
- Immunisation facilitators who provide information to health professionals and the general public to help ensure a safe and effective immunisation programme through immunisation facilitation services.
- The Immunisation Advisory Centre (IMAC) that provides information and education to health professionals and the general public.
- Well Child health promotion services that promote immunisation.
- National Immunisation Register which assists practitioners to identify unimmunised children and provides local, regional and national coverage.

Current status
At the end of quarter four, national immunisation coverage reached the target level of 80 percent.

What are the areas of focus and development for this target?

- To achieve the health target of 95 percent by July 2012, DHBs have been asked to work together and change the way they offer immunisation services. This includes developing regional approaches to immunisation planning and delivery, engaging more with primary health organisations (PHOs) and improving access to the services
- The Ministry will hold quarterly regional meetings with DHBs to review immunisation, examine coverage rates, determine progress, identify any issues and provide guidance on solutions.

How we will measure progress

Immunisation coverage will be measured using the National Immunisation Register. Achieving this target will require different rates of improvement, and some DHBs will have final targets above or below 95 percent coverage. These will be set by the DHB in negotiation with the Target Champion. This target will be reported for Māori, Pacific (where relevant) and other ethnic groups.

Progress towards the health target will be assessed quarterly and the Ministry will monitor progress.

Health Target 5: Better help for smokers to quit

Target Indicator
80 percent of hospitalised smokers will be provided with advice and help to quit by July 2010; 90 percent by July 2011; and 95 percent by July 2012. A similar target for primary care will be introduced from July 2010 or earlier, through the PHO Performance Programme.

Target Champions - Dr Ashley Bloomfield, National Clinical Director
Professor Bruce Arroll, General Practitioner

Why is this target area important?
Smoking kills an estimated 5000 people in New Zealand every year, and smoking-related diseases are a significant opportunity cost to the health sector. Most smokers want to quit, and there are simple effective interventions that can be routinely provided in both primary and secondary care.

This target is designed to prompt providers to routinely ask about smoking status as a clinical 'vital sign' and then to provide current smokers with brief advice and an offer of support to quit. There is strong evidence that brief advice is effective at prompting quit attempts and long term quit success. The quit rate is improved further by the provision of effective cessation therapies – pharmaceuticals, in particular nicotine replacement therapy (NRT), and telephone or face-to-face support.

How we provide services to better help smokers to quit
In 2007 Smoking Cessation Guidelines were updated, introducing a new approach for all healthcare workers to meet the needs of smokers known as ABC. Healthcare workers are prompted to: **A**sk all patients about their smoking status; give **B**rief advice to all smokers to quit; and make an offer of evidence-based **C**essation support (ABC).

The Ministry and DHBs have been working together to implement ABC across the health sector through the ABC programme. Some of the ABC activity underway which supports DHBs in meeting the health target includes:

- DHB Smokefree Coordinators/Tobacco Control Plans
- Clinical Leads
- Training – e-learning and face-to-face
- Accessing NRT on prescription
- Standing orders for NRT
- Referral systems.

Further information on the ABC programme is available at:
http://www.moh.govt.nz/moh.nsf/indexmh/abc-smoking-cessation-framework-feb09

Current status
This is the first year that information has been collected on the new 'Better help for smokers to quit' health target.

What are the areas of focus and development for this target?
This health target is a local target each DHB is individually accountable for. It is expected that DHBs will build on work undertaken to date via the tobacco control plans.

How we will measure progress

This is the first year that the 'Better help for smokers to quit' will be measured in a hospital environment.

The target aims to capture information about treatment offered smokers who are admitted to hospital and DHBs will use standard coding through their Patient Management Systems (PMS) to report on this target.

A baseline measurement is required to assess progress towards meeting the target. In quarter one, DHBs will provide the following data for the period from 1 July to 30 September, which will serve as a baseline measure for the target:

1. Hospitalised smokers
2. Smoking prevalence
3. Percentage of smokers offered advice and support to quit.

From 1 July 2010 the target will be measured in primary care. A process for this will be determined and agreed in 2009/10.

Measuring target achievement

Full Achievement	80 percent target reached in final quarter of 2009/10.
Partial Achievement	Improvement in percent of smokers receiving advice and support increasing from baseline towards target.

Health Target 6: Better diabetes and cardiovascular services

Target Indicators

- Increased percent of the eligible adult population will have had their CVD risk assessed in the last five years
- Increased percent of people with diabetes will attend free annual checks
- Increased percent of people with diabetes will have satisfactory or better diabetes management.

Target Champion - Dr Sandy Dawson, Chief Advisor, Clinical Service Development.

Why is this target area important?

Long-term conditions comprise the major health burden for New Zealand now and into the foreseeable future. This group of conditions is the leading cause of morbidity in New Zealand and disproportionately affects Māori and Pacific peoples. As the population ages, and lifestyles change, these conditions are likely to increase significantly.

Cardiovascular disease (CVD) includes heart attacks and strokes - which are both substantially preventable with lifestyle advice and treatment for those at moderate or higher risk. The indicator monitors the proportion of the eligible population who have had the blood tests for CVD risk assessment (including the blood tests to screen for diabetes) in the preceding five year period.

Diabetes is important as a major and increasing cause of disability and premature death. It is also a good indicator of the responsiveness of a health service to people in most need. The two indicators monitor the access quality improvement programs in primary care and the quality of care and risk of diabetes complications.

Māori and Pacific people are at increased risk from diabetes and cardiovascular disease. Specific targets are agreed for these groups.

How we measure progress

Cardiovascular Disease – CVD Risk Assessment

This indicator is derived from the evidence-based guidelines for the assessment and management of cardiovascular risk.

- The proportion of people in the recommended age ranges for CVD Risk Assessment who have had the fasting lipid group test and a serum glucose or HBA1c test within the previous five year period.

Diabetes

The two national diabetes indicators are based on the evidence-based guidelines for the assessment and management of type two diabetes:

- The proportion of people in New Zealand with diagnosed diabetes who have a Get Checked review each year. This is reported by PHOs to their DHBs. This is an indicator of diabetes diagnosis and reliable follow-up with good quality care.
- The proportion of people with a Get Checked review who had a satisfactory or better diabetes control (as indicated by an HBA1c blood test equal to or less than 8 percent). This is an indicator of quality or effectiveness of care.

How we currently provide CVD risk assessments

Primary care practitioners assess an individual's five-year absolute cardiovascular risk (the likelihood of a cardiovascular event over five years) based on New Zealand's cardiovascular risk charts[3], and provide advice about lifestyle modification and treatment.

The recommended ages for CVD risk assessment are:

Māori, Pacific, and South Asian males:	from age 35
Māori, Pacific, and South Asian females:	from age 45
Other ethnicities - males	from age 45
Other ethnicities - females	from age 55

How we currently provide diabetes services

- The Get Checked/Annual Review programme gives people with diagnosed diabetes an opportunity to consult with their GP and/or nurse each year to check that the important recommendations in the evidence-based guidelines have been completed each year, and to plan the year ahead.
- The Care Plus programme is for people who have to visit a GP or nurse more frequently because of multiple health problems. Many people with poorly controlled diabetes are eligible. Individual care plans are developed for Care Plus patients to set realistic, achievable health and quality-of-life-related goals, with regular follow-ups during the year
- Several PHOs and DHBs are delivering a more comprehensive range of services in the community.
- Hospital-based, multi-disciplinary teams provide support for PHOs and referred patients.
- Non-governmental organisations (NGOs) also provide a range of self-management training and support services.

Current status

- Diabetes Free Checks: The number of people with diabetes who participated in the Get Checked quality improvement programme increased from 88,780 in 2007/08 to 100,249 in 2008/09. Primary healthcare providers are using this programme more effectively to assist their patients in developing on-going diabetes management plans.
- Diabetes Management: In 2008/09 the target for improving the effectiveness of diabetes care improved from 71 percent to 72 percent of people who had "satisfactory or better" diabetes control.
- CVD Risk Assessment: The national target for cardiovascular disease was a 2 percent increase in the proportion of eligible people who had received the laboratory tests for cardiovascular risk assessment in the previous five years. In 2008/09, this national target was exceeded for Māori (2.5 percent improvement during 2008/9), Pacific (4.0 percent), and all New Zealanders (2.3 percent). The New Zealand Cardiovascular Guidelines Handbook has been updated by NZ Guidelines Group. Improvements to information systems and processes are starting to show an improvement in people accessing this service.

What are the areas of focus and development for this target?

- The Quality Improvement Plan for Diabetes and CVD is being implemented collaboratively across the sector

[3] New Zealand Cardiovascular Guidelines Handbook – A summary for primary care practitioners, second edition 2009

- The PHO Performance Programme is being implemented to recognise the extra efforts and resources needed to deliver better health outcomes in primary health care, and includes several indicators for diabetes and CVD
- The New Zealand diabetes guidelines will be updated, and will include more focus on preventing renal disease.

Document 7

10 NOV 2009

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10 NOV 2009
MINISTER'S OFFICE

Health Report Number 20092142

MINISTRY OF HEALTH
MANATŪ HAUORA

Action required by:	13 November 2009	**Date sent to Minister:**	10 November 2009
Minister's reference/ OIA number:		**File number:**	AD62-09-5-3

Hon Tony Ryall
Publication of the Health Targets 2009/10 Summary Report

Advice

1. This Health Report seeks your approval to publish the Health Targets 2009/10 Summary Report on the Ministry of Health's Health Targets webpage.

2. On 27 October 2009, you signed off the Health Report containing the content of the draft introduction for the Health Targets 2009/10 Summary Report, subject to specified amendments (HR 20091587 refers). These changes have now been incorporated into the introduction, final editorial revisions have been made, and design and layout completed.

3. The purpose of the Health Targets 2009/10 Summary Report is to provide a resource to DHBs and the general public. It is intended to be used as a reference document providing base information and context for the six targets, including how they will be measured. It is planned to send out this document to DHBs as part of the package of information to support the publication of their local Health Target results in community newspapers.

4. This report will be published on the Health Targets webpage only as an electronic document (pdf). No hardcopy production is planned.

Recommendations

The Ministry recommends that you:

a) **Note** that on 27 October 2009 you signed off the Health Report containing the content of the draft introduction for the Health Targets 2009/10 Summary Report subject to specified amendments that have now been made. Yes / No

b) **Agree** to publish the Health Targets 2009/10 Summary Report on website Yes/ No

c) **Note** that the Health Targets 2009/10 Summary Report will be published on the Health Targets webpage in pdf format only. Yes/ No

Dr Ashley Bloomfield
Acting Deputy-Director General
Sector Capability & Innovation

MINISTER'S SIGNATURE:
DATE 11/11/09

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DHB Reporting Requirements

2009/10

FINAL

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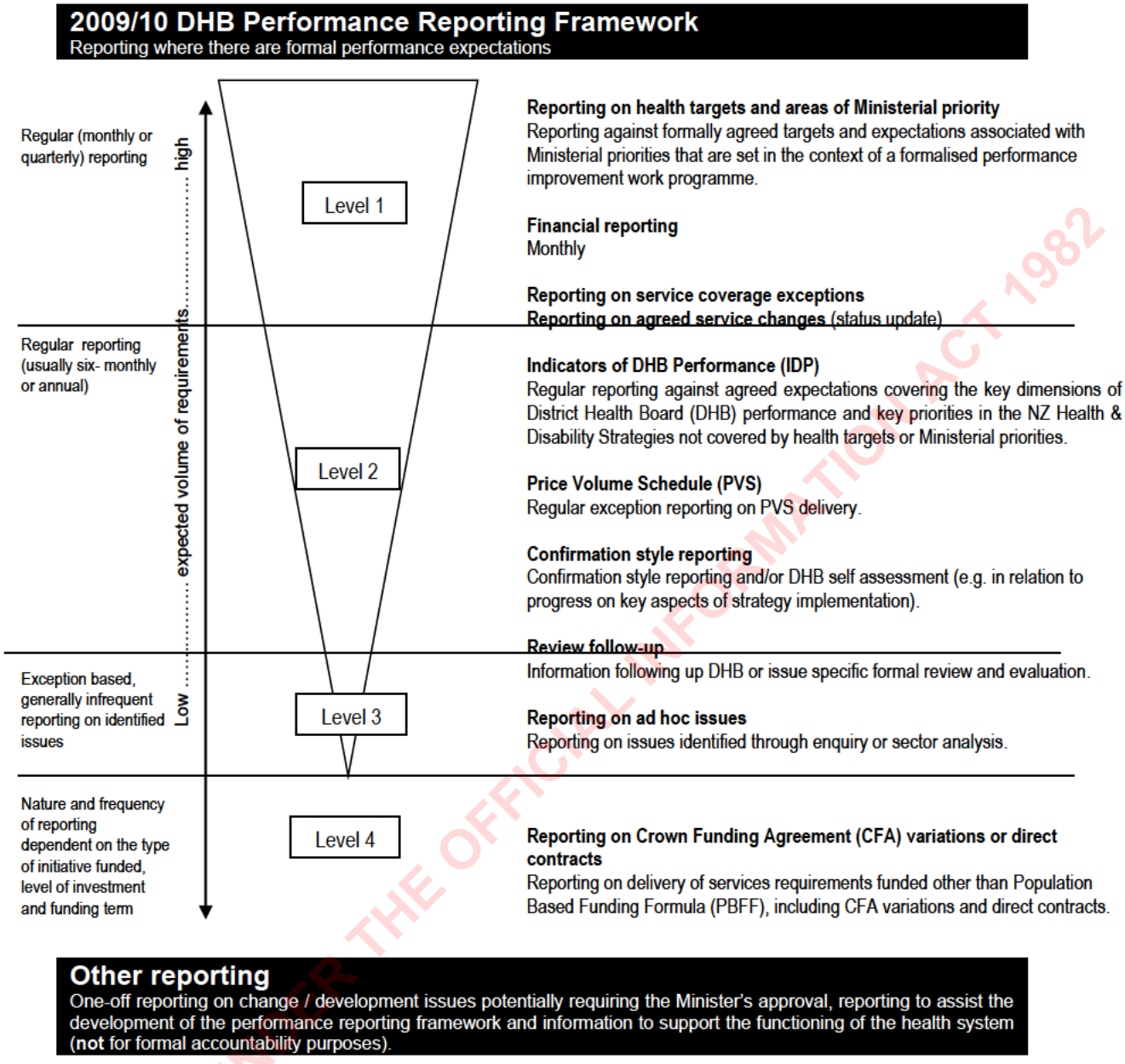

Figure 1: 2009/10 DHB Performance Reporting Framework

Reporting to gain approval for significant change / development

- Definition: proposals and reports relating to the management of service changes and capital and asset management, as required
- Nature of reporting: dependent on the issue – likely to be reporting on a standard template basis for the purposes of Minister level interaction / approval.

Reporting to assist the development of the performance reporting framework

- Definition: not currently performance information, but intended to become performance information in out years i.e. information needed for baseline establishment
- Nature of reporting: dependent on the area of development – restricted to one or two areas of development per year.

Information provision for health system purposes

- Nature of reporting: information provided to national information systems national collections, to support machinery of government, in relation to service specifications, in relation to provider contract reporting, for benchmarking and to support policy development.

2009/10 DHB Performance Reporting Framework
As presented in the diagram on the previous page. The DHB reporting framework has four levels:

- Level 1 – reporting on performance improvement in relation to health targets and key annual priorities
- Level 2 – performance reporting in relation to the key dimensions of DHB performance
- Level 3 – reporting in response to issues identified through enquiry or sector analysis
- Level 4 – reporting on CFA variations and direct contracts.

The performance reporting framework was introduced in 2008/09 to reflect the sector's sharpening focus on and increased effort directed at performance improvement. Reports are focused on the government's key priorities and health targets.

Level 1: 2009/10 Health Targets overview
Each of the health targets reflects a priority health area for the government and aims to focus efforts to improve our performance and ensure our health system is contributing to maintaining and improving health outcomes in these important areas.

Health targets should be seen within the context of the broader health priority that they are part of. They are indicative of progress in a wider range of services provided in each priority area. The targets are also one part of a comprehensive performance management and accountability system in the health sector and are designed to challenge the health system as a whole to continue to do better.

The Sector Capability and Innovation Directorate of the Ministry will proactively work with the sector to build capability, share best practice and innovations, and assist the sector to achieve improved performance and achieve the health targets. Target 'Champions' will continue to provide a leadership role in assisting the sector.

to new developments or risks that are not actively monitored through the IDP arrangements.

Figure 2: 2009/10 Health Targets

Area	Long term Target	2009/10 National target		2009/10 DHB target	
Shorter stays in Emergency Departments	95 percent of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours.	**95%**	of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours	**95%**	of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours
Improved access to surgery	Increase the volume of elective surgery by an average of 4,000 discharges per year (compared with the recent average increase of 1400 per year).	**4,000**	additional discharges	**__**	additional discharges
Shorter waits for cancer treatment	Everyone needing radiation treatment will have this within six weeks by the end of July 2010 and within four weeks by December 2010.	**100%**	of patients in category A, B and C wait less than six weeks between first specialist assessment and the start of radiation oncology treatment (excludes category D patients).	**100%**	of patients in category A, B and C wait less than six weeks between first specialist assessment and the start of radiation oncology treatment (excludes category D patients).
Increased immunisation	85 percent of two year olds are fully immunised by July 2010; 90 per cent by July 2011; and 95 per cent by July 2012.	**85%**	of two year olds are fully immunised by July 2010	**__%**	of two year olds (Maori) are fully immunised by July 2010
				__%	of two year olds (Pacific) are fully immunised by July 2010
				__%	of two year olds (Other ethnicity) are fully immunised by July 2010
				__%	of two year olds (All ethnicities) are fully immunised by July 2010
Better help for smokers to quit	80 per cent of hospitalised smokers are provided with advice and help to quit by July 2010; 90 per cent by July 2011; and 95 per cent by July 2012. Introduce similar target for primary care from July 2010 or earlier, through the PHO Performance Programme.	**80%**	of hospitalised smokers are provided with advice and help to quit by July 2010	**__%**	of hospitalised smokers are provided with advice and help to quit by July 2010

Better diabetes and cardiovascular services	Increased percent of the elig ble adult population have had their CVD risk assessed in the last five years	Increased percent of the eligible adult population have had their CVD risk assessed in the last five years	__%	Increased percent of the eligible adult population (Maori) have had their CVD risk assessed in the last five years (suggestion is 2%)
			__%	Increased percent of the eligible adult population (Pacific) have had their CVD risk assessed in the last five years (suggestion is 2%)
			__%	Increased percent of the eligible adult population (Other ethnicity) have had their CVD risk assessed in the last five years (suggestion is 2%)
			__%	Increased percent of the eligible adult population (All ethnicities) have had their CVD risk assessed in the last five years (suggestion is 2%)
	Increased percent of people with diabetes attend free annual checks	Increased percent of people with diabetes attend free annual checks	__%	Increased percent of people with diabetes (Maori) attend free annual checks
			__%	Increased percent of people with diabetes (Pacific) attend free annual checks
			__%	Increased percent of people with diabetes (Other Ethnicity) attend free annual checks
			__%	Increased percent of people with diabetes (All Ethnicities) attend free annual checks
	Increased percent of people with diabetes have satisfactory or better diabetes management.	Increased percent of people with diabetes have satisfactory or better diabetes management.	__%	Increased percent of people with diabetes (Maori) have satisfactory or better diabetes management.
			__%	Increased percent of people with diabetes (Pacific) have satisfactory or better diabetes management.
			__%	Increased percent of people with diabetes (Other ethnicity) have satisfactory or better diabetes management.
			__%	Increased percent of people with diabetes (All ethnicities) have satisfactory or better diabetes management.

Level 1: 2009/10 Health Targets

Level 1: 2009/10 Health Targets

Progress towards each target will be assessed, reported to the Minister of Health and publicly reported on the Ministry of Health web-site each quarter.

In most cases, specific assessment criterion are set out for each target. Although quarterly progress will be updated on the Ministry of Health web-site, a formal assessment of target achievement will not be made until the final quarter.

Where a health target description does not include specific assessment criterion, the following criterion will apply:

Rating	Abbrev	Criterion
Outstanding performer/sector leader	**0**	1. Applied in the fourth quarter only—this rating indicates that the DHB achieved a level of performance considerably better than the agreed DHB and/or sector expectations.
Achieved	**A**	1. Deliverable demonstrates targets / expectations have been met in full. 2. In the case of deliverables with multiple requirements, all requirements are met. 3. Data, or a report confirming expectations have been met, has been provided through a mechanism outside the Quarterly Reporting process, and the assessor can confirm.
Partial achievement	**P**	1. Target/expectation not fully met, but the resolution plan satisfies the assessor that the DHB is on track to compliance. 2. A deliverable has been received, but some clarification is required. 3. In the case of deliverables with multi-requirements, where all requirements have not been met at least 50% of the requirements have been achieved.
Not achieved – escalation required	**N**	1. The deliverable is not met. 2. There is no resolution plan if deliverable indicates non-compliance. 3. A resolution plan is included, but it is significantly deficient. 4. A report is provided, but it does not answer the criteria of the performance indicator. 5. There are significant gaps in delivery. 6. It cannot be confirmed that data or a report has been provided through channels other than the quarterly process.

Shorter stays in Emergency Departments (ED)

Indicator: 95 percent of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours.

Note that a target date for achievement will be set once current performance data has been collected.

Target Champion – Mike Ardagh, Professor of Emergency Medicine

Rationale

Emergency Department (ED) length of stay is an important measure of service quality in emergency departments, because:

- EDs are designed to provide urgent (acute) health care; the timeliness of treatment delivery (and any time spent waiting) is by definition important for patients
- long stays in emergency departments are linked to overcrowding of the ED
- the medical and nursing literature has linked both long stays and overcrowding in EDs to negative clinical outcomes for patients such as increased mortality and longer inpatient lengths of stay
- overcrowding can also lead to compromised standards of privacy and dignity for patients, for instance, through the use of corridor trolleys to house patients.

Definition

Each DHB will be required to submit their numerator data (number of patient presentations to the ED with an *ED length of stay* less than six hours) and their denominator data (number of patient presentations to the ED) to the Ministry **separately for each relevant ED facility**. In addition, for the first and fourth quarters, DHBs are to provide narrative comment on the quality of their data, steps taken to meet the target and improve the quality of emergency department care, and any difficulties encountered with implementation of the target.

Numerator:

The number of patient presentations to the ED with an *ED length of stay* less than six hours.

Denominator:

The number of patient presentations to the ED.

Explanation of terms:

1. *ED length of stay* for a patient equals the time period from *time of presentation*, to *time of admission*, *discharge* or *transfer*.

2. *Time of presentation*; the time of first contact between the patient and the triage nurse or clerical staff, whichever comes first.
3. *Time of admission*; the time at which the patient is physically moved from ED to an *inpatient ward,* or the time at which a patient begins a period of formal observation, whether in ED observation beds, an observation unit, or similar. The physical move will follow, or be concurrent with, a formal admission protocol, but it is the patient movement that stops the clock, not associated administrative decisions or tasks.
4. *Inpatient wards* include short stay units (or units with a similar function). Under certain circumstances, a 'decant' ward designed to deal with surge capacity will qualify as an inpatient ward. Key criteria are that patients should be in beds rather than on trolleys, and be under the care of appropriate clinical staff.
5. *Time of discharge*; the time at which a patient being discharged from the ED to the community physically leaves the ED. For the avoidance of confusion; if a patient's treatment is finished, and they are waiting in the ED facilities only as a consequence of their personal transport arrangements for pickup, they can be treated as discharged for the purposes of this measure.
6. *Time of transfer*; the time at which a patient being transferred to another facility physically leaves the ED.

Inclusions and exclusions:

1. Data provided to the Ministry of Health will be provided at facility level, for all EDs of level 3 and above, within a DHB, according to the role delineation model, as elaborated in the ED service specification. Where a DHB has more than one facility, the overall percentage calculated for the DHB will be a weighted result, not a simple average of the results of individual facilities.
2. All presentations between 00:00 hours on the first day of the quarter, and 00:00 hours on the first day of the next quarter, are included – *excepting;*
3. Patients who do not wait for treatment will be removed from both the denominator and the numerator, and;
4. GP referrals that are assessed at the ED triage desk (using the Australasian Triage Scale), but are then directed to an Admission and Planning Unit or similar unit without further ED intervention, are excluded from the measure (here the term 'ED intervention' can encompass minor procedures such as analgesia or administration of intravenous fluids, for instance).
5. Patients that present to the ED for pre-arranged outpatient-style treatment are excluded from the measure.
6. No exceptions from measurement are made for particular clinical conditions.

In certain situations it may be that good clinical practice or a particular service model will compromise the ability to meet Health Target expectations, and that this will begin to become apparent as data is collected. Where this situation arises, the Ministry will discuss this with the DHB affected, and the definition can be re-interpreted on a case-by-case basis where relevant.

Interpretation

A high percentage is better than a low percentage.

Relationship with triage times

- Previous analysis by the Ministry of Health suggests there is a weak correlation between triage and length of stay.

- Triage data will continue to be collected from DHBs by the Ministry of Health as part of hospital benchmark data reporting and will form a new Indicator of DHB Performance for 2009/10 with triage 1, 2 and 3 rates collected on a quarterly basis.
- As part of an upcoming review of accountability measures, consideration will be given to:
    - extending the reporting of triage rates to include triage 4 and 5
    - tightening the definitions used in triage rate reporting
    - making triage rate reporting a formal accountability measure.

2009/10 Deliverables

Key Information:

Each DHB will be required to submit their data (numerator, denominator) to the Ministry separately for each relevant facility. A reporting template will be supplied by the Ministry.

In addition, for the first and fourth quarters, DHBs are to provide narrative comment on the quality of their data, steps taken to meet the target and improve the quality of emergency department care, and any difficulties encountered with implementation of the target.

Supporting Information:

Other supporting quantitative information will also be provided to the Ministry. There are no targets associated with this information. Instead, it will be used by the Ministry in developing a rounded view of performance against target:

- the admission rate from ED to inpatient settings
- average midnight bed occupancy over all hospital beds.

Information for analysis at local level:

While it will not be collected by the Ministry, each DHB should collect and hold patient-level data that includes the triage level of the patient, and the time of key milestones in the ED patient journey, in particular, the time of presentation, and time for admission, discharge, or transfer. This material may be required for analysis and discussion with the Ministry, if expectations (as set out below) are not met. The Ministry has begun to consider the future collection of this patient-level data through national data collections by 2010/2011.

Reporting period

All quantitative data (including supporting information) is to be supplied quarterly. This information will need to be available by the 20th day following the end of the relevant quarter.

Qualitative narrative is to be supplied in the first and fourth quarters only.

Expectations

All DHBs (and all individual facilities) are expected to achieve a benchmark of 95 percent against this Health Target.

The following achievement scale will be applied:

- achieved = the DHB has met the target percentage for the quarter, and all facilities have also met targets
- partially achieved = the DHB has met the target percentage for the quarter, though some facilities have not reached their target
- not achieved = performance by the DHB has fallen below the target.

For the first and second quarter of the 2009/2010 year, the target will be piloted, with an expectation that modifications may be made to the measure definition for the subsequent quarters based on any flaws uncovered during implementation.

The target would be fully operational in a final form for the four quarters of the 2010 calendar year.

Escalation

From the third quarter of 2009/2010 onward, where any facility fails to achieve its target, the DHB is responsible to carry out an audit of patients with ED length of stay greater than six hours, in order to determine the reasons for failure to achieve target. The audit results and remedial actions should be reported to the Ministry by the quarter following the reported failure to achieve.

Improved access to elective surgery

Indicator: The volume of elective surgery will be increased by an average 4,000 discharges per year (compared with the previous average increase of 1400 per year).

Target Champion – Kieran McCann, Manager, Elective Services

Rationale

As signalled in the 2009/10 Minister's Letter of Expectations, the government wants the public health system to deliver **better, sooner, more convenient** healthcare for all New Zealanders.

Over the period 2000/01 to 2007/08 the number of publicly funded elective surgical discharges rose by an average of 1,432 discharges per annum. The growth in elective surgical discharges did not keep up with population growth over this period. The Minister has set an expectation that the annual increase in elective surgical discharges will improve. The growth in elective surgical discharges will increase access and should achieve genuine reductions in waiting times for patients.

2009/10 Deliverables

The number of elective surgical discharges will increase by an average of 4,000 discharges per annum. Therefore, there will be at least 134,000 publicly funded elective surgical discharges by 2011/12.

DHBs will be required to report on progress quarterly on an exception basis against the target agreed in their District Annual Plan. This level of reporting will provide early warnings of any DHB that may be experiencing difficulty in achieving their annual target and provide the opportunity for corrective actions to be undertaken.

Reporting period

Quarterly reporting. *Note* reporting for this measure operates on a delayed timetable – not as per the Operational Policy Framework – as the hospital activity needed for reporting is not available until one month after the quarter ends. Data will be made available to DHBs via the Electives Services Quickplace website. Electives services Managers, GMs Funding and Planning will be notified via email that the data is available.

Expectations

At a national level DHBs will deliver an average increase of 4,000 elective discharges each year in surgical specialties. Each DHB will identify a minimum level of elective surgery to be provided to the people living in its regions in the 2009/10 District Annual Plan (DAP). The level of surgery to be provided should be determined by the DHB's actual level of service in the previous financial year (2007/08), the level of service planned in the current financial year (2008/09), and the achievement of equitable access to elective surgery relative to other DHBs.

There will be four levels of achievement for this indicator; Outstanding Performer, Achieved, Partially Achieved and Not Achieved. A rating will be determined for each indicator.

Quantitative measures

DHBs will set a target number of publicly funded, casemix included, elective discharges in a surgical specialty (defined by surgical purchase units excluding dental) for people living within the DHB region. Performance will be measured using data from the National Minimum Data Set (NMDS).

Achievement Levels

	Full Year	**Quarterly (year to date)**
Outstanding Performer	DHB delivers at least 5% more elective surgical discharges than their agreed target.	DHB delivers at least 5% more elective surgical discharges than their agreed target.
Achieved	DHB delivers their agreed target number of elective surgical discharges.	DHB delivers their agreed target number of elective surgical discharges.
Partially Achieved	DHB does not deliver their agreed target but delivers more elective surgical discharges than the previous year.	DHB delivers less than their agreed quarterly target but submits a report that meets Ministry approval by providing the reasons for under-delivery and an action plan as to how it will address the under-delivery and achieve the full year target.
Not Achieved	DHB delivers less than the number of elective surgical discharges required for partially achieved (above).	DHB delivers less than their agreed quarterly target and either does not submit a report or does not submit a report that meets Ministry approval.

Baseline information

Elective services health target baselines can be found on the Ministry of Health website under Health Target Reporting.
http://www2.moh.govt.nz/QuickPlace/electiveservices/Main.nsf

Shorter waits for cancer treatment

Indicator: Everyone needing radiation treatment will have this within six weeks by the end of July 2010 and within four weeks by December 2010.

Target Champion – John Childs, National Clinical Director Cancer Programme

Rationale

Specialist cancer treatment and symptom control is essential in reducing the impact of cancer. Development of indicators that mark quality cancer treatment is, however, restricted by the lack of routinely collected information on common treatment. In the interim, waiting times for radiation oncology treatment have been chosen as a representative indicator of specialist treatment, and is an area with waiting time issues for patients. This is justifiable, because radiotherapy is of proven effectiveness in reducing the impact of a range of cancers, and delay to radiotherapy is likely to lead to poorer outcomes of treatment. A **six week wait time is currently targeted**. The expectation will move to **four weeks by December 2010.**

2009/10 Deliverables

1. Cancer Centre DHBs – wait time templates
Completed monthly templates that measure the interval between the patient's first specialist assessment and the beginning of radiation treatment along with other related measures, are supplied on time and complete from each Cancer Centre as detailed in the reporting template located on the nationwide service framework library web site **NSFL homepage:** http://www.nsfl.health.govt.nz/.

1. All DHBs – Confirmation and exception reports
Provide a report confirming the DHB has reviewed the monthly wait time templates produced by the relevant Cancer Centre(s) for the quarter. Non-cancer centre DHBs should source this information from Cancer Centre DHBs .

Where the monthly wait time data identifies:

- any patients domiciled in the DHB waiting more than 6 weeks, due to capacity issues, and/or
- wait time standards were not met, for patients in priority categories A and B

DHBs must provide a report outlining the resolution path that has been agreed with the cancer centre.

Interpretation issues

First specialist assessment is currently used as a proxy for a formal decision to treat. It is intended that the indicator is adjusted to measure the time between a formal decision to treat and the start of radiation treatment, as soon as data on decision to treat data can be reliably collected by all cancer centres.

Wait times outside the acceptable treatment standard occur either when a service is facing capacity issues or when a patient chooses to wait for treatment or there are

clinical reasons for delay. Where there are clearly identified reasons for delays, other than service capacity issues, the target will be treated as met.

Reporting period

Deliverable 1 - Monthly supply of templates (within 2 weeks of the end of the month).

Deliverable 2 – Quarterly supply of confirmation and exception reports.

Target Expectations

Achievement Levels

- A **not achieved** rating will apply where for one month or more in the period under review there were some patients who did not receive radiation oncology treatment within six weeks of their first specialist assessment (excluding Category D).
- A **partial achievement** rating will apply where for two of the three months under review, all patients received radiation oncology treatment within six weeks of their first specialist assessment (excluding Category D).
- An **achieved** rating will apply where for all of the months under review, all patients receive radiation oncology treatment within six weeks of their first specialist assessment (excluding Category D).
- An **outstanding** performer/sector leader rating will apply, at the end of the 12 month period, where all patients are treated within four weeks of their first specialist assessment (excluding category D).

Increased immunisation

Indicator: 85 percent of two year olds are fully immunised by July 2010; 90 per cent by July 2011; and 95 per cent by July 2012.

Target Champion – Pat Tuohy, Chief Advisor, Child and Youth Health

Rationale

The national immunisation goal is 95% of children fully immunised at two years of age by ethnicity.

Immunisation can prevent a number of diseases and is a very cost-effective health intervention. Immunisation provides not only individual protection for some diseases but also population-wide protection by reducing the incidence of diseases and preventing them spreading to vulnerable people. Some of these population-wide benefits only arise with high immunisation rates, depending on the infectiousness of the disease and the effectiveness of the vaccine. New Zealand's current immunisation rates are low by international standards and are not sufficient to prevent measles or reduce the impact of whooping cough.

Coverage for 2-year olds tells us whether children have received the full series of infant immunisations when they are most vulnerable and also tells us which children are not being reached by our immunisation system. It is a commonly-used measure internationally. Measuring coverage at different ages provides more information about the immunisation system; for example the coverage level of 6-month olds indicates the timeliness of their first immunisations; coverage of 5-year olds indicates the level of immunity for children at school, and coverage of the boosters given to 11-year olds indicates immunity levels in adolescents. Coverage data for older children will become available from the National Immunisation Register over time, the first cohort of children in the register were born in 2005 and are turning 4 this year. These other measures remain important and will be monitored by DHBs and the Ministry but keeping the Health Target simple provides focus, and increasing coverage for 2-year olds will require improvements in the whole immunisation system that should increase the other measures as well.

2009/10 Immunisation Coverage Targets

Immunisation coverage will be measured using the National Immunisation Register. Achieving this target will require different rates of improvement, and some DHBs will have final targets above or below 95 percent coverage. These will be set by the DHB in negotiation with the Target Champion. This target will be reported for Maori, Pacific (where relevant), and Other ethnic groups.

DHB local targets are to be set for:

- DHB total
- Māori

- Pacific.[1]

DHBs are expected to set targets that will reduce inequalities. This will be demonstrated by presenting and agreeing Māori and Pacific targets (where relevant). DHBs should set targets with the aim of eliminating inequalities by 2012.

Note: To assist with setting the immunisation health targets, see the section below called: "Obtaining immunisation coverage baselines to assist with setting the 2009/10 immunisation coverage health targets – National Immunisation Register (NIR) Datamart report instructions."

Assessing DHB Immunisation Coverage

Progress towards the health target will be assessed quarterly.

The target will be assessed on the based on 3 months data for the previous quarter.

The assessment requirements for each quarter are set out below:

Table 1: Quarters 1, 2 & 3 assessment

Rating	Explanation
Achieved	The DHB has reached the year's total population immunisation coverage target for children 24 months of age (as agreed with Target Champion, and as documented in the District Annual Plan).
Partially Achieved	The DHB's immunisation coverage is progressing towards achieving the target for children 24 months of age (as agreed with Target Champion, and as documented in the District Annual Plan).
Not Achieved	The DHB's immunisation coverage has made no progress in the last two quarters or is worsening.

[1] The requirement to set a Pacific target applies only to those DHBs with high Pacific populations. These DHBs are: Counties Manukau, Auckland, Waitemata, Waikato, Capital & Coast, Hutt Valley and Canterbury DHBs.

Table 2: Quarter 4 assessment

Rating	Explanation
Outstanding Performer	• The DHB has substantially exceeded the year's immunisation coverage target for children 24 months of age (as agreed with Target Champion, and as documented in the District Annual Plan); **and/or** • The DHB has reached the year's immunisation coverage target for children 24 months of age for: o the total population, **and** o the Maori population group, **and** where applicable o the Pacific population.
Achieved	The DHB has reached the year's total population immunisation coverage target for children 24 months of age (as agreed with Target Champion, and as documented in the District Annual Plan).
Partially Achieved	The DHB's immunisation coverage is progressing towards achieving the target for children 24 months of age (as agreed with Target Champion, and as documented in the District Annual Plan).
Not Achieved	The DHB's immunisation coverage has failed to substantially progress towards the target for children 24 months of age (as agreed with Target Champion, and as documented in the District Annual Plan).

2009/10 Deliverables

How to report on immunisation coverage and progress towards the targets

Each quarter, DHBs are expected to report on progress towards the immunisation coverage health targets.

DHBs will access information from the NIR Datamart to report on their progress towards the target. A User Guide will be available to assist DHBs with extracting and reporting immunisation coverage data from the NIR Datamart.

Reporting period
Quarterly- assessed on the basis of results from the previous quarter.

Obtaining immunisation coverage baselines to assist with setting the 2009/10 immunisation coverage health targets - NIR Datamart report instructions

<u>Percentage of eligible children fully immunised at 24 months of age – total DHB population, Māori and Pacific</u>

- Use the NIR Datamart 'BC CI Milestone Ages DHB' report.

- For the 'Report to date': use the first day of the previous month[2].
  1. For example if today's date is 15 April 2008, use 1 March 2008 and enter '01/03/2008' as the 'Report to date'

- Print the report from the '3 month' tab

- Use the 24 month milestone age data in the report from the 'Total', 'Māori' and 'Pacific' columns.

[2] The first day of the previous month is used to ensure the complete month's data has been loaded onto the NIR Datamart.

Better help for smokers to quit

Indicator: 80 percent of hospitalised smokers will be provided with advice and help to quit by July 2010; 90 percent by July 2011; and 95 percent by July 2012. Similar target for primary care will be introduced from July 2010 or earlier, through the PHO Performance Programme.

Target Champion – Ashley Bloomfield, Chief Advisor Public Health

Rationale

Smoking kills an estimated 5000 people in New Zealand every year, and smoking-related diseases are a significant opportunity cost to the health sector. Most smokers want to quit, and there are simple effective interventions that can be routinely provided in both primary and secondary care.

This target is designed to prompt providers to routinely ask about smoking status as a clinical 'vital sign' and then to provide brief advice and offer quit support to current smokers. There is strong evidence that brief advice is effective at prompting quit attempts and long term quit success. The quit rate is improved further by the provision of effective cessation therapies – pharmaceuticals, in particular nicotine replacement therapy (NRT), and telephone or face-to-face support.

Definition and Interpretation

Eligible population:

- Hospitals: all adults 15+ admitted to hospital either acutely or for elective procedures
- Primary Health Organisations: 15 to 75 years old enrolled in the PHO
- Provider Arms: 15 to 75 years old inpatients

2009/10 Deliverable

???

Reporting period

Quarterly- assessed on the basis of data /qualitative report YTD ?a 12 month rolling average?.

Expectations

The primary care target will be monitored via the PHO Performance Programme indicators, which include recording of smoking status. This target will require smoking status to be routinely asked about, recorded, and then acted on through offering brief advice to quit and referral for further quit support. Activities are already underway to support GPs and other professionals to do this, including making NRT available on prescription from the middle of this year. The lead-in time for this target is to allow

primary care to put in place the changes needed both to provide this advice and support to smokers routinely and to monitor progress in achieving the target.

The tobacco target is a local target each DHB is individually accountable for. The expectation in 2009/2010 is that DHBs will build on work undertaken to date via the tobacco control plans. Progress towards meeting the target will demonstrate an upwards trajectory through the first year to meet the target by forth quarter. This target will be reported for Māori, Pacific, and Other ethnic groups.

Achievement Levels

- A **not achieved** rating will apply where
- A **partial achievement** rating will apply where
- An **achieved** rating will apply where
- An **outstanding** performer/sector leader rating will apply

Better diabetes and cardiovascular services

Indicator: Indicator:
(a) increased percent of the eligible adult population will have had their CVD risk assessed in the last five years
(b) increased percent of people with diabetes will attend free annual checks
(c) increased percent of people with diabetes will have satisfactory or better diabetes management.

Target Champion – Sandy Dawson, Chief Advisor, Clinical Service Development

Rationale
Chronic disease comprises the major health burden for New Zealand now and into the foreseeable future. This group of conditions is the leading cause of morbidity in New Zealand, and disproportionately affects Māori and Pacific peoples. As the population ages, and lifestyles change, these conditions are likely to increase significantly.

Diabetes is important as a major and increasing cause of disability and premature death, and it is also a good indicator of the responsiveness of a health service for people in most need.

Reporting period
To be reported quarterly[3]. Quarterly for the period to end of previous quarter.

Timing of reporting should occur as follows:
- in the first quarter, DHBs should report on rates to 30 June of the previous year
- in the second quarter, DHBs should report on rates to 30 September of the previous year
- in the third quarter, DHBs should report on rates to 31 December of the previous year
- in the fourth quarter, DHBs should report on rates to 31 March of the previous year.

Health target:	Cardiovascular disease (CVD)
Indicator:	CVD Risk Assessment (CVDRA)
Deliverables:	The absolute percentage increase in the following indicator over the annual reporting period: **Numerator:** The number of people in the eligible population who have had the laboratory blood tests (lipids and glucose or HBA1c) for assessing absolute CVD risk in the last five years. **Denominator:** The number of people in the eligible population.

[3] Note: Quarterly reporting for the diabetes indicators are those detection and management measures from the annual Get Checked data. Get Checked spreadsheets are still to be completed in full, in the third quarter.

	The population eligible for CVDRA is as follows: 1. Māori/Pacific & Indian subcontinent men 35-79 years of age 2. Māori/Pacific & Indian subcontinent women 45-79 years of age 3. NZ European & other men 45-79 years of age 4. NZ European & other women 55-79 years of age. This target will be reported for Māori, Pacific, and Other ethnic groups. DHB performance against targets will be distributed quarterly by the Ministry of Health to all DHBs.
Commentary:	The PHO Performance Programme includes an indicator based on CVD risk assessment, which is reported by PMS systems and forwarded to PHOs. Aggregate (non-identifiable) data is reported by the PHO to the national PHO Performance Programme. However, this data will not be available in a robust enough form for use in establishing targets and reporting as a national target during 2009/10. For this reason, it has been decided to use an **interim indicator for CVD based on laboratory data**. This decision is based on the assumption that whenever a CVD risk assessment is performed, the individual must have had a fasting lipid group test (FLG) and a serum glucose or HBA1c (if the person has diabetes). The national laboratory warehouse data will be used to identify the proportion of individuals with one or more FLG, and one or more glucose or one or more HBA1c test in a five year period. The Ministry expects that the PHO Performance Programme data will be available to use to establish targets for the 2010/11 year.

Health target:	Diabetes detection and follow-up
Indicator:	Proportion estimated to have diabetes accessing free annual checks
Deliverables:	**Numerator:** (Data source: DHB) The number of unique individuals with type I or type II diabetes on a diabetes register, whose date of their free annual check is during the reporting period (reported for Māori, Pacific, and Other ethnic groups). **Denominator:** (Data Source: the Ministry distributes this to all DHBs for DAP planning) The expected number of unique individuals to have type I or type II diabetes, as at the start of the reporting period (reported for Māori, Pacific, and Other ethnic groups).

Health target:	Diabetes management
Indicator:	Proportion on the diabetes register who have satisfactory or better diabetes management (HBA1c = 8.0% or less)
Deliverables:	**Numerator:** (Data source: DHB). The number of people with type I or type II diabetes on a diabetes register that had an $HbA1_c$ of equal to or less than 8% and at their free annual check during the reporting period (reported for Māori, Pacific, and Other ethnic groups). **Denominator:** (Data Source: DHB). The number of people with type I or type II diabetes on the diabetes register, whose date of their free annual check is during the reporting period (reported for Māori, Pacific, and Other ethnic groups).
Commentary:	This indicator will be aligned with the PHO Performance Programme in future. Indicators based on HBA1c are challenging to improve in communities, but remain the best predictor of diabetes complications. This indicator has been validated in the USA as a measure of "quality-adjusted life years saved".

Document 9

MINISTRY OF HEALTH
MANATŪ HAUORA

Health Report number: 20101544

Action required by: routine

Date sent to Minister: December

Minister's reference: not applicable

File number: AD62-09-5-3

To: Hon Tony Ryall

Title: Update on progress and activities to support achievement of the Shorter Stays in Emergency Departments Health Target

Executive summary

i. This briefing provides an update on progress and activities to support achievement of the Shorter Stays in Emergency Departments Health Target (the Target). It also provides initial advice on future options for the Target and potential supporting accountability and quality measures.

The Ministry recommends that you:

a)	**Note:** the DHBs identified as at 'high' and 'moderate/high' risk of not achieving the 95 percent target by 30 June 2011.	Yes / No
b)	**Note:** the Ministry will provide further advice to you on supporting accountability and quality measures for emergency departments and acute services, following the current consultation process with the sector.	Yes / No

Please note that we are trying to reduce administrative burden & if more data needs to be collected then we need to look at what doesn't need to be collected anymore.

Margie Apa

Deputy Director-General

Sector Capability and Implementation Directorate

Ryall

Minister's Signature

Date: 11 10 12

Pse note "Hospital Leader" article attached

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MINISTRY OF HEALTH
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Advice

1. The Shorter Stays in Emergency Departments Health Target (the Target) came into effect on 1 July 2009. This briefing describes the current and intended activities to support achievement of the Target, including an assessment of each DHB's risk of not achieving the 95 percent target by the end of the 2010/11 year. It also provides initial advice on future options for the Target and potential supporting accountability and quality measures.
2. An overview of the activities and progress achieved against the Target to quarter one of 2010/11 is provided in Appendix 1.

Current and intended activities to support DHB achievement of the Target

3. *Focusing activities on 'high' and 'moderate/high' risk DHBs:* All DHBs have agreed through their District Annual Plans to aim to achieve the 95 percent target in 2010/11. The Ministry considers that some DHBs are unlikely to achieve the Target within this timeframe however. Provided in Appendix 2 is a table which identifies for each DHB the level of risk that it will not achieve the 95 percent target by the end of the 2010/11 year. This assessment of risk is based on the DHB's performance to-date and knowledge of the challenges they face. The Ministry's Shorter Stays in ED team is currently focusing its activities on supporting those DHBs identified as at 'high' and 'moderate/high' risk through regular contact, including further visits if needed, to review and advise on their progress and activities.
4. *ED Services Advisory Group:* The ED Services Advisory Group includes representation from emergency clinicians (including doctors and nurses) and will continue to be used to provide advice on the Ministry's work programme and activities and to provide a clinical network with the sector.
5. *Development of guidance on bed management:* Achieving the Target is dependant on good patient flow throughout the whole hospital and bed management is a key factor in hospital flow. However, it is apparent that DHBs approach bed management in a range of ways with differing levels of success. In response to this, and with an aim to improve national consistency of bed management processes, the Ministry has begun reviewing international and local approaches to bed management. The Ministry has also been in contact with the New Zealand Nurses Organisation who have expressed interest in providing input to this piece of work.
6. *Promotion of clinical pathways:* For some common presentations to the ED, clinical pathways can be used to improve the quality of care by identifying and standardising best practice. For example, chest pain is a very common reason for presentation to the ED but the process to 'rule out' acute coronary syndrome (ACS) varies. The Ministry intends to work with DHBs and clinicians to identify opportunities for where standardised clinical pathways could be introduced and to promote the use of these through the Health Improvement and Innovation Resource Centre (HIIRC).
7. *Emergency Services Service Specification:* The Ministry intends to start the process of updating the Emergency Services Service Specification, which is currently overdue.
8. *Top ten challenges to improving performance:* Through visiting each of the DHBs and reviewing their 'Delivery Plans for Shorter Stays in ED' the Ministry has gained a national overview of the challenges facing DHBs in their pursuit of better acute care and achievement of the Target. An overview of the ten challenges that appear most prevalent is provided in the table below. These challenges were discussed at the New Zealand ED conference in Taupo in October 2010 and a paper is currently being written for possible publication in the New Zealand Medical Journal. It is intended that by sharing this information it will initiate discussion on how to respond to these challenges as well as helping to focus the Ministry's efforts to provide support and advice.

Rank	*Barrier/challenge*	*Further information*
1=	Access to hospital beds:	Includes no bed available and no appropriate bed available (e.g. isolation room). (NB. Delays to discharge and difficulty accessing aged care beds are listed as separate barriers below, however they also limit access to hospital beds for new patients).
1=	Access to diagnostic testing	Mainly CT scanning.
1=	Inpatient team delays	Delays waiting for inpatient registrar review of patients in the ED. Some hospitals do have areas (e.g. Medical Assessment and Planning Units) to overcome this.
4	Increased demand for ED services	
5=	ED facility deficiencies	In terms of either size or layout, as well as the ability to stream patients to specific areas within (or outside) the ED staffed and equipped to meet their needs.
5=	ED staff deficiencies	Can be senior, junior, nursing or a combination.
7	Delays to discharge of inpatients	Occupying beds that need to be made available for new patients needing to be admitted from the ED. Often the peak of ward discharges does not occur until well after the peak in ED presentations causing a backlog of patients needing to be admitted.
8	Difficulty engaging hospital clinical staff in changes	Leadership and collaboration are key. Need to demonstrate the whole-of-system nature of the Target.
9	Difficulty accessing aged care beds	Limited numbers of aged care beds and difficulty returning patients back to aged care facilities.
10	Nights and weekends	Cannot expect the ED to be the only solution at nights for covering both the wider hospital and primary care needs.

Future options and potential accountability and quality measures to support the Target

9. The National Clinical Director of ED Services, Prof Mike Ardagh, continues to reinforce that genuine improvements in the quality of patient care are more important than performance against the Target. Pressure to perform against the Target needs to be judiciously applied so that DHBs improve patient care without resorting to measures that improve compliance against the Target but do not improve patient care. The National Clinical Director considers that support for the Target among clinicians is essential to its success, and that this support is dependent upon clinicians believing that the Target is driving genuine improvements in quality. Demanding too tight a timeline may therefore have the effect of undermining quality and support for the Target.

10. The Ministry has produced a discussion document about appropriate performance measures for New Zealand EDs and acute care. This document has been sent for initial consultation to the Health Quality and Safety Commission, the Health Roundtable, the ED Services Advisory Group, and the National Clinical Director for Urgent and Emergency Care from the English National Health Service.

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11. The discussion document recommends that the current target of 95 percent in six hours is retained in New Zealand for the foreseeable future. This approach was supported by participants at the recent national ED conference.

12. The National Clinical Director visited the United Kingdom in July this year and was advised by English clinical leaders, who have had experience of a 98 percent in four hours target, that the final push from 95 percent to 98 percent achievement was difficult, costly and seemed to do little to improve genuine quality. The issue of what timeframe is preferable was less clear in these discussions but overall there was a clear sentiment that six hours and 95 percent was a better choice than four hours and 98 percent. Since the election, the new government has announced that the current 98 percent in four hours target will change to 95 percent in four hours early next year, as a transitional step before the target is replaced altogether later in the year by a suite of quality measures.

13. Western Australia has also been implementing a four hour target, modelled after the English four hour target, since 2009. Anecdotal reports of progress suggest hospitals are struggling with the demands of this target. The Australian government has stated an intention that other states will also adopt a four hour target, although there is opposition to this from ED clinicians.

14. In addition to retaining the current Target measure, the discussion document recommends that DHBs be required to collect and internally monitor an agreed suite of performance and quality measures. It is envisaged that the suite of measures would span the spectrum of acute care - from primary care, though secondary services (including ED), to post-hospital primary and community care – and would be developed in collaboration with the Health Roundtable and DHBs to ensure that they are acceptable to all, and have standard definitions and appropriate benchmarking.

15. The measures would complement the ED length of stay target by providing a concrete and comparable measure of the quality and outcomes of acute care. While ED length of stay is associated with poor outcomes and poor patient experience, it does not in itself define poor outcome or experience (a short length of stay might coexist with a bad experience and poor outcomes and vice versa).

16. Primarily, the measures would be used by DHBs for improvement and quality purposes and would not need to be reported centrally to the Ministry. However, they could be reviewed by the Ministry if there were concerns about quality or gaming of the Target. This differs from the approach in England where the new suite of performance measures will be used as 'accountability' measures, reported to the Department of Health on a regular basis. The Ministry's discussion document however, argues that good quality improvement measures, when used for accountability purposes, lose much of their quality improvement value. Hence, it is not recommended that DHBs be required, as routine, to submit this information to the Ministry.

17. Following the document's consultation, the Ministry will advise you on the views of those consulted, and our recommended approach for future measurement of EDs and acute care.

Minister's feedback

	Very poor	Poor	Neutral	Good	Very Good
Quality of advice	1	2	3	4	5
Writing style	1	2	3	4	5
Quality of analysis	1	2	3	4	5
Completeness of information	1	2	3	4	5

Comments:

END.

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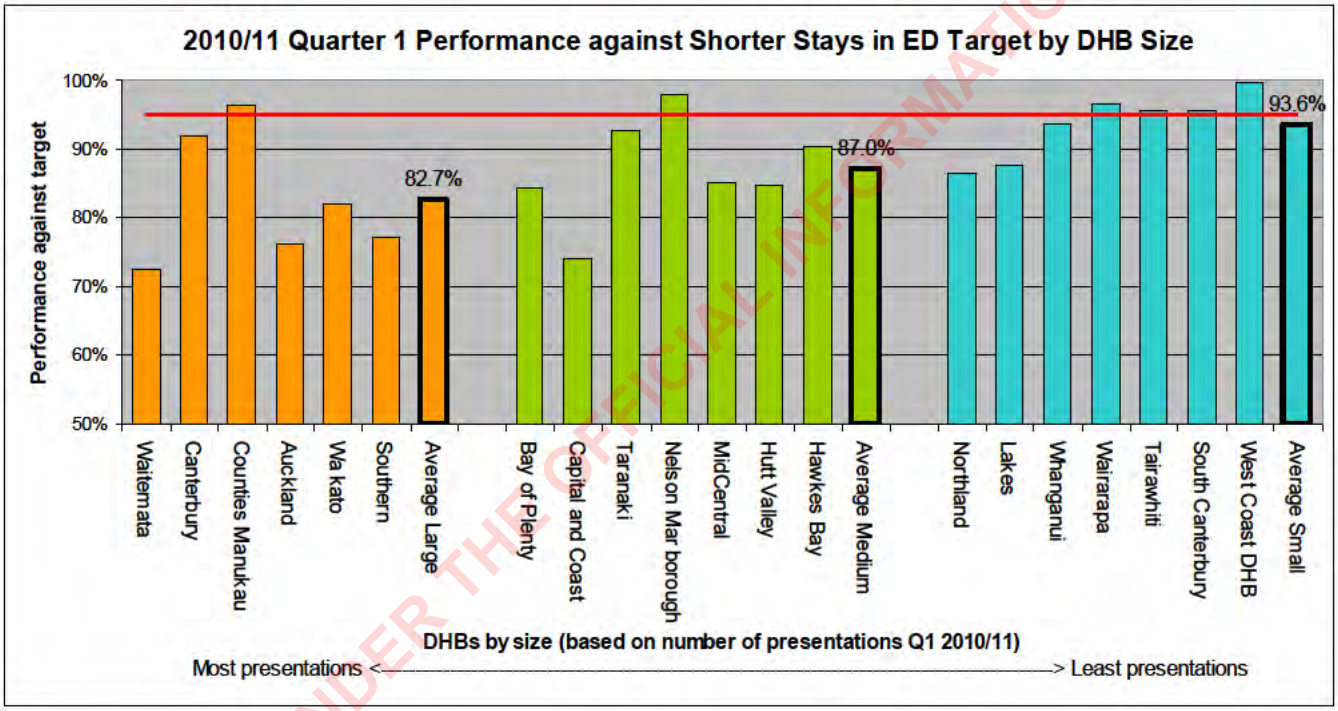
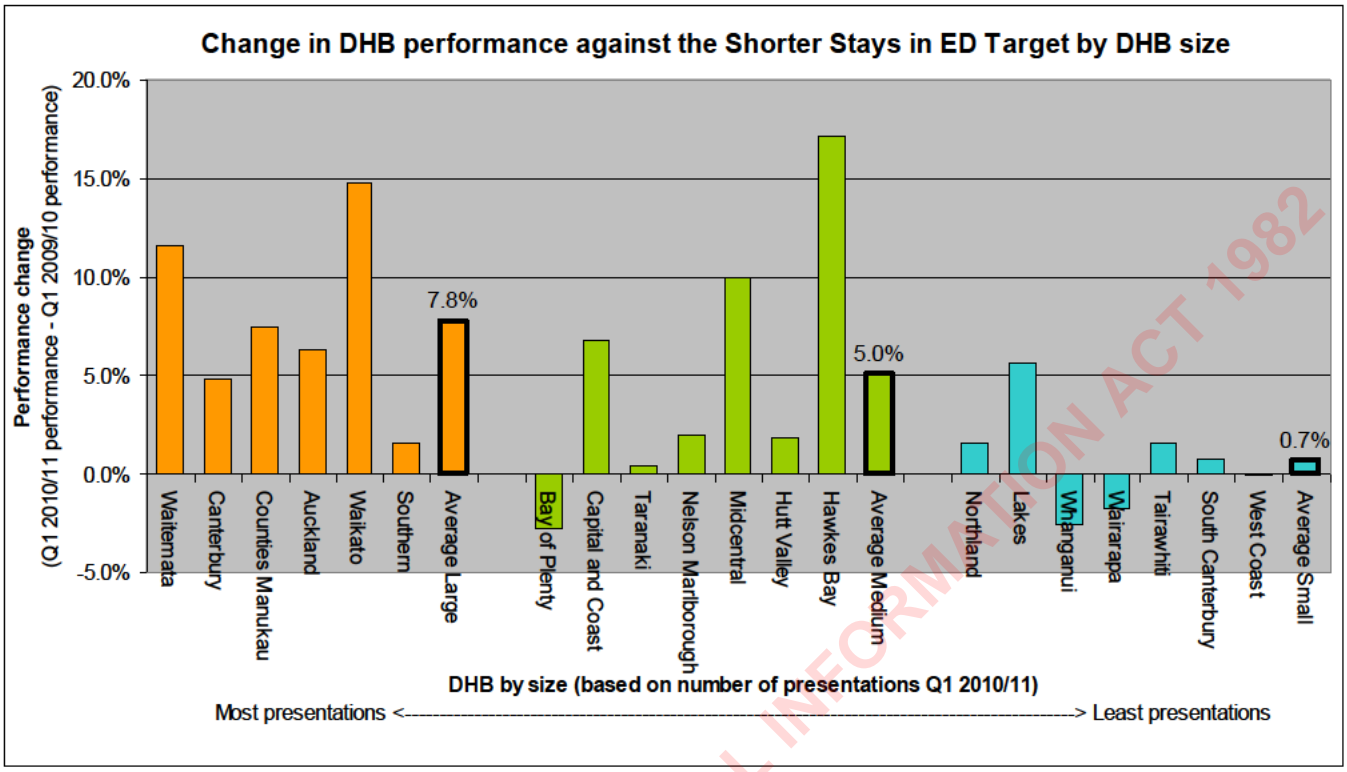
Appendix 1: Progress achieved against the Target to quarter one of 2010/11

18. Overall DHB performance against the Target has increased by 5.3 percent, from 80.3 percent in quarter one of 2009/10 to 85.6 percent in quarter one of 2010/11. Six DHBs (West Coast, Nelson Marlborough, Wairarapa, Counties Manukau, South Canterbury and Tairawhiti) achieved the 95 percent target in quarter one of 2010/11, which is one more than in quarter one of 2009/10.

19. There is a relationship between the number of ED presentations and DHB performance, with smaller hospitals and DHBs generally performing better against the Target. This is illustrated by the graph below of performance as at quarter one of 2010/11 which orders DHBs by the number of ED presentations they had in the quarter. The performance of Counties Manukau and Canterbury DHBs in particular however, demonstrate that the Target is achievable even in large, complex hospitals.



20. The DHBs with the highest numbers of ED presentations have all recorded increases in performance to quarter one of 2010/11. Hawkes Bay DHB has achieved the largest increase in performance of 17.1 percent. The graph below illustrates the change in each DHBs performance to quarter one of 2010/11, with the DHBs ordered as above by the number of ED presentations they had in quarter one of 2010/11.



21. The National Clinical Director is generally pleased and encouraged by the improvements in performance achieved by DHBs, and particularly the larger DHBs, to-date. Progress has been steady which indicates a focus on genuine quality improvement. DHB performance against the Target is expected to continue to improve during 2010/11 once the winter period, with its associated acute demand pressures, has passed.

Activities completed to-date to support DHB achievement of the Target

22. Each DHB has been visited at least once to gain an understanding of their specific challenges, initiatives and successes and to provide advice and facilitate progress as appropriate. The visits followed a standardised format of meetings, usually involving DHB management, ED staff (doctors, nurses and others), clinical staff from in-patient specialities, and staff responsible for bed management and patient flow. A tour of the ED and other facilities was also included. Following each visit, a report was provided to the DHB (with an opportunity for the DHB to review and comment) summarising the discussions and making recommendations about how the DHB might respond to the identified barriers.

23. To ensure meaningful and lasting improvements to the quality of acute care were planned, each DHB was required to develop and submit a 'Delivery Plan for Shorter Stays in ED' outlining their comprehensive, prioritised, whole-of-system plan to improve ED quality and length of stay. The Delivery Plans include identification of the DHB's local contributors to long ED stays, the intended actions to respond to these and who is responsible for delivery of the actions.

24. Four meetings of the ED Services Advisory Group, which includes representation from emergency clinicians (including doctors and nurses) providing a clinical network with the sector, have been held. This group provides a forum to discuss emerging issues and activities under the work programme and has provided advice and input into guidance documents produced by the Ministry.

25. A 'Guidance paper for New Zealand EDs regarding the interface with primary health care' has been developed. From interactions with sector it became apparent that there are varying perceptions of what the interface between ED and primary care should look like and how it should operate. Consequently there can be disagreement and confusion about issues such as 'inappropriate' ED attendance, 'triaging away' from the ED and whether EDs duplicate care available in primary care. It was in response to this that the Ministry developed the paper to provide some guiding principles for those who develop and deliver hospital ED services about how they should relate to and interact with primary health care. This paper went out to the sector for consultation with feedback received from DHBs, professional organisations (including the Royal New Zealand College of General Practitioners and the New Zealand Medical Association) and others (including the Health and Disability Commissioner). The feedback was generally supportive and the paper is now in the process of being finalized before a final version is released to the sector.

26. Development of an ED section on the Ministry website and on the Health Improvement and Innovation Resource Centre (HIIRC). HIIRC is the primary means of sharing information and ideas, and promoting discussion on common issues of implementation. An ED-themed HIIRC newsletter in November 2010 saw a substantial increase in the number of HIIRC views on the day of the newsletter release.

27. Other activities to support DHBs included:

- Development of a guidance document clarifying national expectations and suggested approaches towards the Target;
- Development of a guidance document on ED observation and inpatient assessment units to describe and define their functions and how they should be used;
- Posters for DHBs to use to internally promote the Target;
- Two newsletters (in November 2009 and March 2010) providing an update on the Target to maintain profile and share information on both national and local initiatives;
- The Improving the Patient Journey Workshop in Christchurch in May-June of this year had a strong focus on the Target and was well attended by DHB staff working in the Target areas;
- Sessions on the Target at the national meetings of senior DHB clinicians and management, including DHB Chief Operating Officers (COOs), Chief Medical Officers (CMOs) and General Managers Planning & Funding.

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Appendix 2: Risk assessment of each DHB

Risk level	DHB	Comments supporting risk ranking
High risk	Auckland DHB	Auckland has made good progress, although the adult hospital ED remains one of the poorest performing in New Zealand. They have identified significant challenges which they are working through, but progress is unlikely to see achievement of the Target by the end of 2020/11.
	Bay of Plenty DHB	Bay of Plenty has performed good diagnostic and planning work, but has been slow to see the implementation of initiatives and, most importantly, progress consequent to initiatives. Momentum seems to be developing now, but the 95 percent target is probably too distant to achieve by the end of 2010/11.
	Capital & Coast DHB	Capital & Coast made good initial progress after opening its Medical Admissions and Planning Unit (MAPU), but has since stagnated. More recent attention to their efforts is promising further increments of progress, but with a long way to go.
	Southern DHB	Both Otago and Southland DHBs were struggling with the demands of this Target prior to the merger, although Southland was beginning to show signs of progress. The merger and other pressing issues appear to have contributed to a distraction of focus from the Target. Otago continues to struggle with some of the fundamental prerequisites for success, and although good intentions are starting to work through the issues, it remains unlikely that it will get close to the 95 percent target.
	Waikato DHB	Waikato displayed very good initial progress, but then fell back after the loss of some influential leadership. A recent intensive visit by the National Clinical Director has resulted in recommendations for a significantly reformatted approach. Progress is expected as a result, although it is unlikely to reach 95 percent by the end of 2010/11

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High risk	Waitemata DHB	Waitemata is making good progress but started a long way back. It is unlikely to reach 95 percent by the end of 2010/11 for this reason.
Moderate/high risk	Hutt Valley DHB	Hutt Valley has consistently suggested it will not make 95 percent prior to the opening of its new ED. It is possible, but not particularly likely, that encouragement to do so may see 95 percent achieved by the year end.
	MidCentral DHB	Progress at MidCentral has been steady, but relatively slow.
	Northland DHB	Progress at Northland has been slow, with a delayed application to the required work.
Moderate risk	Canterbury DHB	Canterbury has been consistently in the 90 percent's, but has stagnated at about 92 percent. It will find achieving the final few percent very challenging.
	Lakes DHB	Lakes has performed relatively poorly compared to other DHBs of its size, but new leadership in the ED from mid-December 2009 could result in the speed of progress being quickened and the remaining percent needed being achieved.
	Taranaki DHB	Taranaki stayed at 92-93 percent throughout 2009/10, so is close to achieving the Target but appears to be finding achieving the final percent needed challenging.
Low risk	Tairawhiti DHB	Tairawhiti dropped below the Target during 2009/10 but is now achieving the 95 percent target in quarter one of 2010/11 and should be able to bed in consistent Target achievement during the coming year
	Counties Manukau DHB	Achieved the Target in quarters three and four of 2009/10 and is expected to continue to do so in 2010/11. Has an excellent whole-of-system programme in place that is well supported and well led.
	Hawkes Bay DHB	Achieved the largest improvement in performance during 2009/10 increasing by 19.3 percent to 93 percent in quarter four. Strong CEO commitment has been a key feature of progress made to date.

Low risk	Nelson Marlborough DHB	Achieved the 95 percent target throughout 2009/10 and continues to look for further quality improvements.
	South Canterbury DHB	Achieved the 95 percent target throughout 2009/10. The DHB's approach to the Target has a strong focus on reducing ED demand which is appropriate for its population.
	Wairarapa DHB	Achieved the 95 percent target throughout 2009/10 with good attention to the right things.
	West Coast DHB	Achieved the 95 percent target throughout 2009/10 and will likely continue to do so in 2010/11 due to small size. However, the DHB has been warned that they do need to apply some attention in this area otherwise pressure will build.
	Whanganui DHB	Achieved the 95 percent target in the first three quarters of 2009/10. Although the DHB has not achieved the Target in quarter four of 2009/10 or quarter one of 2010/11, continued focus should see the DHB achieve the Target again in 2010/11.

Document 9

HOSPITAL LEADER

Quality First, Finances Follow

Tuesday, August 10, 2010

When Addressing ED Throughput, Don't Forget To Check The Back Door

Yesterday's post covered the anticipated increase in ED visits for most hospitals because of the impact of healthcare reform. As hospitals prepare for this they will most certainly look to improve ED throughput, which is certainly what I would recommend. Many efforts I have seen hospitals attempt focus on the front door of the ED to get patients into the system faster. This is important but it is usually only part of the solution to faster throughput in the ED.

A number of approaches have been tried to get patients into the treatment cycle faster. Door to doc time or door to treatment time is a metric we all look at. Some innovative approaches have been used to shorten this. Some of them work and some of them don't. For example, hospitals have tried a policy of not using the waiting room unless absolutely necessary. The idea is to have enough treatment rooms in the ED to whisk new arrivals instantly into a room. This gives them the idea that treatment has begun. But the plan backfires when a patient waits an hour in a room without seeing anyone. Its like entering a crowded restaurant and immediately getting a table only to wait an hour for the waiter to show up. To improve throughput you need to begin service earlier.

But while many hospitals do effectively reduce waiting on the front end, fewer recognize the impact of the backlog on the back end of the ED. I'm talking about the patients waiting to be admitted upstairs. Disposition to Admit time is the metric to look at. Admit is defined as the patient has left the ED and is in an inpatient bed on a unit. Not all EDs recognize the significant impact this can have on ED throughput, patient satisfaction, ED productivity and ultimately new ED business.

The primary reason that ED patients who need admission remain in the department is the lack of available beds upstairs. We sometimes see a lack of cooperation from nursing staff to accept new patient in available beds, but usually its because the beds are full. And often they are full with patients who have been medically ready to be discharged for hours. They just haven't left yet. This is often because they are waiting on a family member who works or because the attending physician makes rounds late. These are both challenging issues but they can be addressed. We have helped many hospitals do it.

So when focusing on improving ED throughput, don't forget to address the inpatients lingering in the beds upstairs. Your ED bottleneck may well be bigger at the back door than it is at the front.

More on this later.

Mark Brodeur

Posted by Mark Brodeur, FACHE at 10:10 AM

0 comments:

Mark Brodeur, FACHE, SVP Compirion Healthcare Solutions

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Health Report number: 20171714

Security classification: In-Confidence

Quill record number:
File number: AD62-14-2017
Action required by: Urgent

Potential next steps to reshape and refresh health targets

To: Hon Dr David Clark, Minister of Health

Purpose

This report responds to your request for advice on "next steps to reshape and refresh health targets to focus more on prevention and reducing inequality of access."

Key points

- Since their introduction in 2007/08, health targets have provided a strengthened focus on improving system performance through the establishment of clear and manageable priorities. Health targets have been successful in shifting sector performance in the areas targeted.
- Health targets have been selected in areas identified as Government and public priorities where it has been difficult to deliver sustained performance improvement, and where faster progress is expected to achieve a significant impact in a relatively short time period.
- There are both short term and longer term opportunities to reframe existing targets, introduce new targets, and repackage the suite of health targets to provide greater emphasis on prevention and equity, while ensuring sustainable performance.
- Ministry officials are available to discuss a range of options for framing the suite of health targets and its contribution to the DHB and sector performance story. This could include using health targets in different ways by reframing the overall focus of the targets approach, adjustments to measures within the set and new styles of presentation of performance/results. For example, health targets could be more directly aligned with the desired system shifts described by the New Zealand Health Strategy, or focused on new or emerging government priorities, or be more strongly focused on service and system integration etc.
- There are some practical considerations in target selection and implementation. Health targets need to deliver meaningful change in a two to three year period, be supported by service providers; be easily understandable by the public and have sufficient volume of activity to be able to reflect DHB level results, even for smaller DHBs, on a regular basis. A development period is likely to be necessary, particularly if data to support the target is not currently used for performance reporting. Experience has shown that phasing allows the sector to implement and shift resources and capacity to one or two totally new target areas at a time.
- The Ministry would like to discuss with you:
  - the overall approach to framing and packaging of the health targets
  - potential changes to the current health targets that could be included in February 2018 planning advice for implementation from 1 July 2018
  - examples of options for new areas of target focus/new approaches to existing target areas, reflecting a greater emphasis on prevention and equity that could be explored for inclusion in 2019/20 planning advice, for 1 July 2019 implementation. Including options to refresh the approach for framing and presenting health target results.
- Separate advice has been provided to you [refer HR 20171709] summarising the current approach to improving elective care and providing options to adjust the electives health for 2018/19.

Contacts:	Clare Perry, Group Manager , Integrated service design, Service Commissioning	S9(2)(a)
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MINISTRY OF HEALTH
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Health Report number: 20171714

Potential next steps to reshape and refresh health targets

Recommendations

The Ministry recommends that you:

c)	**Agree** to meet with Ministry officials to discuss possibilities for reframing overall health target approaches, examples of options for changes to health targets that could be implemented for 1 July 2018, and 1 July 2019, and potential changes to the presentation of health target results.	**Yes/No**

Jill Lane
Director
Service Commissioning

Minister's signature:

Date:

MINISTRY OF HEALTH
MANATŪ HAUORA

Health Report number: 20171714

Potential next steps to reshape and refresh health targets

Overview of the health targets

1. Health targets have been included within DHB performance frameworks since 2007/08 when they were introduced to provide a strengthened focus on improving system performance through the establishment of clear and manageable priorities.

2. The current health targets are a set of six national performance measures that sit within wider sector accountability arrangements and alongside other key measures of system level performance, quality improvement and population outcomes. Each of the key measure sets has a role in supporting aspects of performance improvement and in prioritising system performance.

3. The particular role that health targets play within these frameworks is as a focus for action in areas identified as Government and public priorities, where it has been difficult to deliver sustained performance improvement, and where faster progress is expected to achieve a significant impact in a relatively short time period. Because health targets are primarily a tool for supporting service performance improvement, the primary audience for health targets are the leaders of service providers and their teams, who are delivering the service improvement needed to meet the target goals. It is also important that the targets positively impact health outcomes and inequities and are meaningful to the public.

4. The current health targets, excluding electives [refer HR 20171709], operate without supporting financial rewards or penalties. Relationship based processes and reputation effect are the key performance levers, this includes public reporting of results in a league table form supported by individual communication of each DHB's achievements, and facilitation of shared learning.

5. Health targets have been successful in shifting sector performance in the areas targeted. Although not all national goals have been met, all targets have seen substantial improvements in performance from baselines.

6. Collective responsibility has been a key focus. Ministry of Health target champions are in place for each health target to support poorer performers, share best practice and identify changes required to achieve success in the target. Strong DHB governance level engagement in the health targets has been a key driver for local performance improvement, and the Ministry has observed that DHBs with strong health target performance have a combined emphasis on system, leadership and culture within their approaches that is also providing a platform for wider service improvements.

Changes to the health target approach

7. There are opportunities to reframe the overall health target approach, this could include a new focus for health targets as a performance tool. For example rather than primarily driving service related performance in areas of government or public priority, target approaches could be more strongly focused on integration, or improving health literacy etc. A refresh of the targets could also provide an opportunity to more directly align targets with the desired system shifts described by the New Zealand Health Strategy (the Strategy). All existing targets except 'Raising Healthy Kids' predate the current Strategy and have therefore not been considered for their potential to drive implementation of the Strategy.

8. A strengthened focus on targets which reflect reducing inequalities is aligned with the 'Value and high performance' theme, which is about "striving for equitable health outcomes for all New Zealand population groups" (pg 25). Through their focus on access to services, long term conditions and prevention, all existing targets, as a group, provide a level of support for the 'Closer to home' theme of the Strategy. All DHBs have explicitly aligned their local health target activities to a strategy theme in their Annual Plans.

9. If a continued focus on service-related performance is agreed, there are opportunities to enhance the focus on prevention and equity within this approach, to make adjustments to measures within the set, and to implement new styles of presentation. Some examples of options for changes to

health targets that could be implemented for 1 July 2018, and 1 July 2019, and changes to presentation of health target results are outlined below.

10. Practical considerations for health target selection and implementation, are noted later in this report, one key consideration is ensuring there is sufficient volume of activity to be able to reflect DHB level results, even for smaller DHBs, on a regular basis. A development period will be necessary particularly if data to support the target is not currently used for performance reporting. The opportunities to identify new targets for inclusion in February 2018 planning signals for implementation from 1 July 2018 are limited, however some changes could be made to the current target set and to the way results are presented to begin to refocus on equity.

Potential changes to the current health target set for implementation 1 July 2018

11. The Ministry has reviewed the current set of six targets. Where data allows, current targets could be adjusted to provide an enhanced equity focus, including in the presentation of results and this could be signalled in February 2018 planning signals for implementation from 1 July 2018. In addition, for the Immunisation target, a new focus on five-year-old immunisation coverage and a phased introduction of antenatal immunisation for pertussis (whooping cough) are also suggested. A change to the Emergency Departments (ED) target could be made to explicitly focus on acute admission from ED. Potential changes to the electives health target are identified in separate advice [HR 20171709].

Examples of potential options for new targets of health target focus / new approaches to existing target areas for 1 July 2019 implementation

12. The Ministry considers there are a range of additional areas where there are known inequalities and inequities, where a prevention focused health target has the potential to support the pace of performance improvement and reduce hospitalisations. All of these areas would require a development period to assess if a target approach is appropriate, consideration of where to focus a target measure and goal including an evaluation of evidence regarding performance improvement approaches.

13. Once a potential target focus is identified, development would involve key stakeholders and include a detailed assessment against target selection criteria, confirmation of baselines and consideration of technical details such as systems for data capture etc.

14. Examples of options for new targets are outlined below, a selection from the options below could be developed for your consideration with a view to implementation from 1 July 2019:

- long term conditions[1] - explore options focused on prevention and equity
- healthy ageing - explore options linked to the healthy ageing strategy
- immunisation new focus - explore options focused on antenatal pertussis immunisation
- childhood obesity - explore options to focus on later growth measurement (i.e. year 9) and /or a focus on healthy child and youth nutrition, physical activity and sleep, better prevention and equity
- cancer - explore options including expanding the patient cohort/ or replace with a wider measure of hospital access
- smoking - explore options to shift focus to smoking cessation and equitable benefits.
- acute demand - explore options to focus on managing acute demand and providing acute care in the right setting and reducing avoidable hospitalisations.

15. The following options for future health target focus have also been considered. For the reasons outlined below, the Ministry's view is that these areas are not appropriate for further development as health targets at this stage:

[1] Long term health conditions include cardiovascular disease, chronic respiratory conditions, cancer, mental health conditions, diabetes and musculoskeletal conditions. (Refer page 22 NZ Health Strategy: Future Direction)

- maternal and child health – currently the focus of other measure sets. From July 2017 reductions in potentially avoidable hospitalisations for children (0 to 12), and early enrolment with a Lead Maternity Care are the focus of the health-led Better Public Service targets. These measures are in the early stages of implementation; however, baselines are in place and intervention logic has been developed. Ambulatory sensitive (avoidable) hospitalisation rates for 0 to 4 year-olds is currently one of the system level measures that provide a framework for continuous quality improvement and system integration.
- mental health access – decisions about the development of a mental health target are most appropriately considered as part of work related to the mental health inquiry.
- suicide prevention – decisions about the development of a suicide prevention health target are most appropriately considered in alignment with work related to the mental health inquiry.
- oral health - the Ministry has considered options for an oral health target. The oral health initiative identified as most likely to prevent dental decay and reduce inequalities is community water fluoridation (CWF). The effectiveness of water fluoridation in preventing dental decay is supported with a body of evidence and a programme of work is already underway. The Health (Fluoridation of Drinking Water) Bill, which proposes that DHBs rather than local authorities can decide which community water supplies are fluoridated, is currently awaiting its second reading in the House. Measuring CWF coverage would not be appropriate as a health target, however subject to the Bill passing, the Ministry is seeking the opportunity to develop a performance measure to maintain or increase CWF coverage nationally. This could be signalled to DHBs in various ways, such as your Letter of Expectations or through the annual planning process.

Options to refresh the approach for presenting results

16. In addition to changes to the focus of the suite of health targets, there are also opportunities to refresh the format for health target publication and reframe the way health target results are presented to provide more emphasis on reducing inequalities.

17. Public reporting was introduced based on evidence that performance approaches that rely on improving results simply by providing information to professionals and managers are relatively poor levers. However, where an organisation's performance is publicly reported the organisation responds to perceived threats to their 'reputation, status and professional pride' as long as there is a high and sustained level of publicity attached to performance measurement.

18. Health target results are currently published as paid advertisements in national newspapers and the NZ Doctor publication as well as on Ministry and DHB websites. Discontinuing the use of print media to publish results would provide a cost saving, although some of the benefits of public reporting may be reduced if the health target results were solely reported on web sites as this may lessen the impact of reputational effect as a performance lever.

19. The Ministry has undertaken some preliminary work to investigate processes for reporting health target results through other news media platforms such as 'stuff'. However, preliminary investigations did not suggest there would performance benefits or cost savings from this type of approach.

20. Changes to the style of presentation of health target results have also been considered and greater focus on reducing inequalities could be included in the presentation of health target results from quarter one of 2018/19.

- This could be achieved by including an additional column on the health target results table to indicate if the result is equitable across specified population groups. For example the inclusion of a = or ≠symbol.
- The Ministry has also considered introducing more colour into the results tables such as different colours for each target icon. This would provide more visual interest and allow for a clearer distinction between the target areas. (Note additional use of colour does not impact on the cost of publication).

21. Some immediate changes to target presentation could be applied for 2017/18 quarter two results to reflect feedback from the sector and provide more focus on positive achievement as outlined below:

    - The sector has previously requested that results tables more clearly distinguish when a target is met and that ranking does not occur for DHBs at or above target.
        - o This could be achieved by the use of green shading for any DHB that has met the target goal and/or allocation a ranking of "1" for all DHBs at or above target.
    - The sector has also previously requested that if a target is achieved by a DHB, arrows indicating the comparison with previous quarters are not included, reducing the potential for inappropriate focus on small upward and downward movements between quarters when a DHB is already performing at or above the national goal.

Approach to target selection

22. Targets are selected with a presumption that a degree of performance shift towards the target goal is measurable year-on-year. Targets may remain in place for a longer period where improvements require system-wide changes to be embedded. Some areas of current focus such as elective services, cancer waiting times and immunisation coverage have been in place since 2007/08. However the specific goals and measures for these targets have evolved over time. Raising Healthy Kids is the newest area of focus, with the current target introduced in quarter one of 2016/17.

23. A range of criteria are applied when considering potential new targets. These include the significance of the outcome sought, noting in particular your greater emphasis on prevention and reducing inequalities, measurability, data robustness, and the evidence base for intervention logic that supports performance improvement activity along with wider criteria more specific to the national targets regime.

24. The number of health targets at any one time has ranged between six and ten. Experience has shown that a target set of six is an appropriate size to ensure focused performance approaches and improvements are achievable across the targets.

25. Any targeting regime needs to consider the potential for unintended consequences such as gaming of results and inappropriate diversion of resources. Approaches to minimise the impact of unintended consequences have included careful target selection, sector engagement from target champions, DHB governance level engagement, and an emphasis on reputational effect via publishing of results that rank DHBs as a performance lever, rather than financial incentives or sanctions.

Implementation of new targets and transition processes for removal of targets

26. Changes to health targets form part of the DHB annual planning processes, this means once development work is completed and a target is agreed with you it will be widely consulted with the sector through annual planning consultation and finalised in annual planning advice.

27. When a target approach has achieved its maximum benefit, the target measure is typically moved to the set of DHB accountability measures for a period. This helps ensure performance gains are not lost in the transition away from the focus of the health targets programme. It can also be useful to phase in the introduction of a new target by including the intended measure as a DHB accountability measure for a period to support establishment of baselines and frameworks for data capture, reporting and service improvement.

END.

Document 11

Briefing

Cabinet paper: Implementing Health System Indicators - a new measurement framework for publicly reporting health system performance

Date due to MO:	22 January 2021	**Action required by:**	5 February 2021
Security level:	IN CONFIDENCE	**Health Report number:**	20210013
To:	Hon Andrew Little, Minister of Health		

Contact for telephone discussion

Name	Position	Telephone
Clare Perry	Acting Deputy Director-General, Health System Improvement and Innovation	S9(2)(a)
Dean Rutherford	Group Manager, Health and Disability Intelligence	S9(2)(a)

Minister's office to complete:

☐ Approved ☐ Decline ☐ Noted

☐ Needs change ☐ Seen ☐ Overtaken by events

☐ See Minister's Notes ☐ Withdrawn

Comment:

Cabinet paper: Implementing Health System Indicators - a new measurement framework for publicly reporting health system performance

Security level:	IN CONFIDENCE	**Date:**	25 January 2021
To:	Hon Andrew Little, Minister of Health		

Purpose of report

1. This report provides you with the draft Cabinet paper - *Implementing Health System Indicators - a new measurement framework for publicly reporting health system performance* (known as the Health System Indicators), which is intended for the Social Wellbeing Committee (SWC) meeting on Wednesday 17 February, and the Cabinet meeting on Monday 22 February 2021.
2. To meet the Cabinet meeting deadline, the paper will need to be lodged with the Cabinet Office by 10:00am on Thursday 18 February 2021.

Summary

3. The attached Cabinet paper provides Cabinet with an update on the previous decisions made by the Minister of Health, along with previous Cabinet decisions, to progress the implementation of the Health System Indicators framework [Health Report 20200148 refers].
4. The paper seeks Cabinet agreement for you to publicly communicate the implementation of the Health System Indicators.
5. Talking points are provided in Appendix One of this Briefing.
6. A summary of the Health System Indicator measures to be consulted on with sector partners is provided in Appendix Two of this Briefing.

Recommendations

We recommend you:

a) **Agree** that the Cabinet paper - *Implementing Health System Indicators - a new measurement framework for publicly reporting health system performance* is lodged with the Cabinet Office by 10:00am on Thursday 18 February 2021. **Yes/No**

b) **Note** that we have drafted the Cabinet paper to authorise you to make the final implementation decisions by June 2021.

c) **Note** that Treasury and DPMC have signalled support for a financial measure to be included in the Health System Indicators framework.

d) **Agree** to:

i. Not progress a financial measure as part of the Health System Indicators framework *(recommended)* **Yes/No**

ii. Progress a financial measure as part of the Health System Indicators framework, noting that the Ministry of Health will undertake work to identify suitable potential indicators. **Yes/No**

e) **Note** the talking points provided in Appendix One.

f) **Note** the Health System Indicator measures provided in Appendix Two.

Clare Perry

Clare Perry
Acting Deputy Director-General
Health System Improvement and Innovation
Date: 21 January 2021.

Hon Andrew Little
Minister of Health
Date:

Cabinet paper: Implementing Health System Indicators - a new measurement framework for publicly reporting health system performance

Background

7. In December 2019, Cabinet agreed to a new framework for publicly reporting health system performance [CAB-19-MIN-0664 refers]. Cabinet authorised the Minister of Health to finalise 10 high-level measures after consultation with health sector experts.

8. The multi-level framework included 10 high-level measures linked to 5 Ministerial health priorities. District health boards (DHBs) were to identify and implement local actions to advance these priorities.

9. In July 2020, the former Minister of Health, Hon Chris Hipkins agreed to the following (HR 20201178 refers):

   - for the new framework to be known as the 'Health System Indicators'
   - three main changes to the measures. The measures to be replaced are:
     - 'people reporting being treated with kindness and respect' with 'people report being involved in decisions about their care and treatment'
     - 'amenable mortality rate' with 'ambulatory sensitive hospitalisations for adults (age range 45-64')
     - 'under 20s able to access specialist mental health or addition services within three weeks of referral' with 'follow up within seven days post discharge from an inpatient mental health unit'
   - the outline of the web-based reporting platform
   - that the Ministry of Health (Ministry) and the Health Quality and Safety Commission (HQSC) report back in November 2020 on the final set of high-level measures following consultation with health sector experts
   - that the Ministry and the HQSC report back in March 2021 on the results of data available in quarter two 2020/21 (October-December 2020) for four high-level measures for online publication
   - that the Ministry and the HQSC report back in November 2021 on the results of data available in quarter one 2021/22 (July-September 2021) for the 10 impact measures for online publication.

10. In September 2020, the Ministry provided the former Minister of Health the proposed Cabinet paper that sought Cabinet agreement to retire the national health targets. Cabinet agreement was also sought for the Minister of Health to publicly introduce the new Health System Indicators framework and make

decisions on the design and implementation of the Health System Indicators. Due to the prioritisation of the COVID-19 response and the upcoming general election, this paper was not taken to Cabinet.

11. In anticipation of a public announcement, the Ministry and the HQSC have briefed a selection of key sector leaders and clinicians on the framework over July and August 2020 to gauge their responses. Overall, there is positive feedback from the sector groups briefed to date.

Implementation timing

12. The Ministry, in partnership with the HQSC, is leading the implementation of the framework. Implementation requires significant sector engagement and technical development, and this work is likely to continue until at least April 2021. We will provide an update on progress via the Weekly Report at the end of March 2021.

13. Public reporting of results will be through an interactive web-based reporting platform. A high-level national summary (by ethnicity) will be published with public communication of the framework. A newspaper-based reporting of results is not intended at this time.

14. Due to the impact of COVID-19, timelines previously approved by Cabinet for public reporting have not been met. For example, public reporting of DHB level data was set to begin in November 2020. Work was intentionally slowed to avoid the need for DHBs and clinical experts to engage in a new piece of work while their collective focus needed to be exclusively on the COVID-19 preparedness and response. This, in combination with the timing of the general election, meant that no public announcement of the launch of the indicators was made, and so no sector consultation on the detail of the measures occurred.

15. Once Cabinet approval has been obtained, we propose the following: a two month sector consultation, refinement of the Health System Indicators, and finalisation of the measure set for implementation in 2021/22. You would then confirm the approach to the identification of the baseline information. National baselines would be published in June 2021 prior to the implementation of the Health System Indicators from 1 July 2021.

16. We have amended the earlier draft of the Cabinet paper, which required further Cabinet approval, to now authorise the Minister of Health to make final design and implementation decisions about the Health System Indicators.

17. The DHB annual planning guidance for 2021/22 will explicitly include the Health System Indicators. Public reporting of both national and DHB progress against the Health System Indicators will begin in Quarter one of the 2021/22 financial year.

18. Appendix Two shows the proposed Health System Indicators and public reporting timelines.

Retiring the national health targets

19. The new Health System Indicators framework replaces the previous six national health targets.

20. Under Ministerial direction, the Ministry has continued to update the health target results on the Ministry of Health website each quarter since August 2018.

21. The national health target for 'Improved access to elective surgery' was retired by the previous Minister of Health at the end of June 2018. For the purposes of clear accountability, it will be important to formalise a retirement date for the remaining five health targets within DHB accountability arrangements. This should be coordinated with the introduction of the Health System Indicators framework, with the national health targets being retired on 30 June 2021, and the last reporting being in August for the June 2021 quarter.

Considering an additional measure on financial performance

22. Both The Treasury and the Department of the Prime Minister and Cabinet (DPMC) have signalled support for a financial measure to be included in the framework.

23. Considering this, and with DHBs' financial performance being an area of ongoing performance pressure, you sought our advice on the usefulness of including a measure for financial sustainability in the Health System Indicators framework.

24. Additional focus from DHBs on prudent financial management is critical. However, this would need to be carefully managed as part of any suite of public measures. There is some risk that presenting a financial sustainability measure alongside improvement measures would detract from the purpose of the Health System Indicators. An unintended consequence could be that such a measure strengthens a narrative that additional funding will solve any issues (DHBs are one part of the health and disability system), rather than being a mechanism for holding DHBs to greater financial accountability.

25. The Ministry and the HQSC note that the purpose of the Health System Indicators framework is about health outcomes, including equity.

26. It is the Ministry's and HQSC's view that the Vote Health appropriation is an input contributing to health outcomes and a financial measure does not need to feature in this framework. Financial performance is not, of itself, a health outcome that is meaningful to New Zealanders. Other publicly available reports on financial sustainability are available, including DHB financial information on the Ministry's website and accountability mechanisms to Parliament.

27. The Ministry and the HQSC also hold the position that a prominent indicator drawing attention to DHB financial performance will likely drive undesirable behaviours that may mask true financial performance or that impact on the health and wellbeing of New Zealanders such as reducing services in order to meet a financial sustainability measure.

28. However, we recognise that any improvements in health outcomes need to be achieved within an approved funding envelope, and that this context needs to be strengthened in any public messaging. On that basis, we would recommend we

continue to make DHB financial performance reports available on the Ministry's website. We recommend that on the Health System Indicators page, additional context around the importance of financial performance be included, with a click through link from the new framework to other published performance reporting that features on the Ministry website, including regular monthly financial reports. The draft cabinet paper has been written on this basis.

29. If you wish to include a financial measure in the Health System Indicators, the Ministry will undertake further work to identify suitable potential indicators. The cabinet paper would be revised to reflect the inclusion of a measure representing 'Financial Performance'.

Equity

30. Improving equity is an important focus in all aspects of the health and disability system. This recognises that people have differences in health outcomes that are not only avoidable but unfair and unjust, and that people with different levels of advantage require different approaches to achieve equitable outcomes.

31. To better understand the scope and nature of equity concerns, indicator data will be disaggregated, where possible and appropriate, by factors such as sex, age (across all age groups including children, youth and older people), ethnicity, and level of deprivation.

32. Additionally, for each indicator, there will be at least one balancing measure of the distribution of that measure among different ethnic and socio-demographic groups. For example, a local intervention to decrease avoidable hospital admissions will not be considered a success if this intervention increases inequity between the Māori and non-Māori populations.

Consultation

33. The attached Cabinet paper has undergone consultation with HQSC, DPMC and The Treasury.

34. The Ministry will continue to engage with The Treasury on the implementation of this framework.

35. The Treasury and DPMC are generally supportive of the paper. They recommended the addition of an indicator for financial sustainability, as noted in Paragraph 22.

Risks

36. There has been significant public, sector, media and political interest in the national health targets and on-going queries and concerns about next steps, including the length of time taken to confirm a new direction.

37. As decisions by the Government were being finalised, the development of the new Health System Indicators framework has not included sector or clinical input. DHBs and clinical leaders will play a crucial role in the successful implementation

of the Health System Indicators framework. Without this support, the Ministry will be unable to effectively implement the Health System Indicators.

38. In order for the Ministry to progress with the implementation of the Health System Indicators framework, including sector consultation of the indicators, a Ministerial announcement of the new framework is necessary.

Next steps

39. The Ministry and the HQSC are ready to progress with the implementation of the Health System Indicators framework following agreement from Cabinet.

ENDS.

Appendix One: Proposed talking points

1. A strong and sustainable health and disability system is essential for the wellbeing and prosperity of New Zealanders.

2. A key lever to drive improved performance across the health and disability system is public reporting on population health outcomes and system activity.

3. In December 2019, Cabinet agreed to a new measurement framework for publicly reporting health system performance. Today I seek your agreement to the implementation of the Health System Indicators framework.

4. This framework reflects at least five Ministerial priorities for the New Zealand health system:

    - improving child wellbeing
    - improving mental wellbeing
    - improving wellbeing through prevention
    - strong and equitable health and disability system
    - primary health care.

5. Improving equity is an important focus in all aspects of the health and disability system. This recognises that people have differences in health outcomes that are not only avoidable but unfair and unjust, and that people with different levels of advantage require different approaches to achieve equitable outcomes.

6. The new framework requires the ongoing strong working relationships between the Ministry, DHBs, primary care and local providers; and close engagement and involvement of consumers.

7. There are 10 indicators that are linked to these health priorities. DHBs will identify and implement local actions to advance these priorities.

8. DHBs' results will be publicly reported through an interactive web-based reporting platform. Balancing measures and baselines will be added to the reporting platform over time, after the measures have been tested with the sector.

9. Public reporting of DHB results was to begin in November 2020. COVID-19 has impacted this timeline. A revised timeline means that public reporting will begin from July 2021.

10. The Ministry of Health, in partnership with the Health Quality and Safety Commission (HQSC), is leading the implementation of the framework. This requires significant sector engagement and technical development, which will continue until at least April 2021.

11. The implementation of the framework and the underlying approach is consistent with the findings of the Health and Disability System Review. The involvement of key stakeholders in developing local actions and contributory measures towards national goals for the Health System Indicators is also broadly consistent with the review's recommendations regarding governance and funding of the system.

12. The new framework will replace the previous six national health targets. Subject to your agreement, I would like to retire the health targets when the Health System Indicators framework is introduced from 30 June 2021.

The following material has been provided in case it comes up during the Cabinet meeting

A high-level measure for financial sustainability

If you decide to not support a financial measure:

1. I would not recommend including a measure for financial sustainability in the Health System Indicators framework.

2. It is my position that a prominent measure drawing attention to DHB financial performance will likely drive undesirable behaviours that may mask true financial performance or that impact on the health and wellbeing of New Zealanders such as reducing services in order to meet a financial sustainability measure.

3. My view is that the health budget is an input contributing to health outcomes, and while an essential factor in providing sustainable healthcare into the future, is not of itself a health outcome that is meaningful to New Zealanders.

4. I acknowledge that the current context of financial constraint is important. However other publicly available reports on financial sustainability are available, including the DHB financial information, on the Ministry's website and accountability reporting to Parliament.

5. A link from the new framework to the Ministry's financial performance reporting can be incorporated into the framework. This would provide a comprehensive picture while reducing reporting burden.

If you decide to progress with a financial measure:

6. If a measure of financial performance is required, the Ministry will undertake further work to identify suitable potential indicators.

Appendix Two: Proposed Health System Indicators and public reporting timelines

Ministerial health priority	Proposed indicators	Indicator description	Public reporting timeline
Improving child wellbeing	Immunisation rates for children at 24 months	Percentage of children who have all the recommended vaccinations by the time they are two.	National level (by ethnicity) from the date of announcement DHB results from November 2021
	Ambulatory sensitive hospitalisations for children (age range 0-4)	Rate of hospital admissions for children under five for an illness that might have been prevented or better managed in the community.	National level (by ethnicity) from the date of announcement DHB results from November 2021
Improving mental wellbeing	Follow-up within seven days post-discharge from an inpatient mental health unit	Percentage of people followed up within seven days after discharge from an inpatient mental health unit.	National level (by ethnicity) from the date of announcement DHB results from November 2021
	Access to primary mental health and addiction services	*New indicator to be finalised by May 2021.*	National level (by ethnicity) when finalised DHB results from November 2021
Improving wellbeing through prevention	Participation in the bowel screening programme	*New indicator to be finalised by May 2021.*	National level (by ethnicity) when finalised DHB results from November 2021
	Ambulatory sensitive hospitalisations for adults (age range 45-64)	Rate of hospital admissions for people aged 45 to 64 for an illness that might have been prevented or better managed in the community.	National level (by ethnicity) and DHB results from November 2021
Strong and equitable public health system	Acute hospital bed day rate	Number of days spent in hospital for emergencies.	National level (by ethnicity) and DHB results from November 2021
	Access to planned care	People who had surgery or care that was planned in advance, as a percentage of the original plan.	National level (by ethnicity) from the date of announcement DHB results from November 2021
Better primary health care	Unmet need in primary care	Percentage of people who say they receive care from a GP or nurse when they need it.	National level (by ethnicity) from the date of announcement DHB results from November 2021
	People report being involved in the decisions about their care and treatment	Percentage of people who say they feel involved in their own care and treatment with their GP or nurse.	National level (by ethnicity) from the date of announcement DHB results from November 2021

In Confidence

Office of the Minister of Health

Chair Cabinet

Implementing Health System Indicators – a new measurement framework for publicly reporting health system performance

Proposal

1 This paper seeks approval to retire the national health targets and for the Minister of Health to publicly communicate the implementation of the Health System Indicators that will be the new measurement framework for publicly reporting health system performance.

Relation to government priorities

2 The implementation of the framework and the underlying approach is consistent with the findings of the Health and Disability System Review. The final review report notes the importance of integrating a long-term set of outcomes and associated performance measures into system planning, including local targets for individual district health boards (DHBs) on which to focus their actions. The framework is also consistent with the 2020 Speech from the throne, including the focus on child and mental health wellbeing.

3 The involvement of key stakeholders in developing local actions and contributory measures towards national goals for the Health System Indicators is also broadly consistent with the review's recommendations regarding governance and funding of the system.

Executive Summary

4 In December 2019, Cabinet agreed to a new framework for publicly reporting health system performance [CAB-19-MIN-0664 refers] to replace the previous six national health targets. The multi-level framework included 10 high-level Health System Indicators linked to 5 Ministerial health priorities. DHBs were to identify and implement local actions and associated contributory measures that can show whether improvement efforts are making a difference in their area. Balancing measures were to be agreed with DHB's and added over time to ensure that improvement activities did not have unintended or undesirable consequences.

5 The Ministry of Health, in partnership with the Health Quality and Safety Commission (HQSC), is leading the implementation of the framework. Implementation requires significant sector engagement and technical development. Technical development work is likely to continue until at least April 2021.

6 I have agreed for the new framework to be known as the 'Health System Indicators'.

7 This paper is seeking three decisions from Cabinet:

7.1 agreement to publicly communicate the implementation of the Health System Indicators framework as our new way of reporting health and disability system performance

7.2 agreement to retire the national health targets at the date of the implementation of the Health System Indicators

7.3 agreement for the Minister of Health to take final decisions on the design and implementation of the Health System Indicators by the end of June 2021.

Background

8 In May 2019, the Cabinet Social Wellbeing Committee invited the then Minister of Health, Hon David Clark, to consider measures to support reporting on key Ministerial priorities for the health and disability system and to report back in due course [SWC-19-MIN-0059 refers].

9 On 9 December 2019, Cabinet agreed to a new framework for publicly reporting health system performance to replace the previous six national health targets [CAB-19-MIN-0664 refers]. This framework will manage and measure health system performance, with the intent of building trust and collaboration at all levels, through accountability supported by public reporting.

10 Due to the impact of COVID-19, and the work coinciding with the General Election, the public launch of the Health System Indicators did not happen as intended. As a result, this has meant that sector consultation, measure confirmation and the public reporting that Cabinet approved by November 2020 was not completed. A revised schedule sets out sector consultation during March and April 2021, and public reporting, planned to begin with the results reported for the September 2021 quarter, to be released in December 2021.

11 The multi-level framework includes high-level health and disability system indicators that measure progress towards the five Ministerial health priorities.

12 The new framework requires the ongoing strong working relationships between the Ministry, DHBs, primary care and local providers; and close engagement and involvement of consumers.

13 The new framework is flexible in order to respond to new priorities and changes in circumstances at local and national levels.

14 I have agreed for the new framework to be known as 'Health System Indicators'.

Analysis

Proposed Health System Indicators

15 Cabinet authorised the Minister of Health to finalise the Health System Indicators after consultation with health sector experts [CAB-19-MIN-0664 refers].

16 In July 2020, following advice from the Ministry of Health and the HQSC, the Minister of Health made changes to three indicators. The indicators to be replaced are:

16.1 'people reporting being treated with kindness and respect' with 'people report being involved in decisions about their care and treatment'. Patients reporting being involved in decisions about care and treatment is a critical component of ensuring patients accept practitioners' advice. Overall, 18 percent of people report not being as involved in decisions about their care and treatment as they wanted to be. This impacts on people's engagement with the health system and the system's ability to deliver patient-centred care.

16.2 'amenable mortality rate' with 'ambulatory sensitive hospitalisations [ASH] for adults (age range 45-64)'. The word 'sensitive' in the term ASH is used deliberately as not all admissions are preventable. ASH admission rates can serve as proxy markers for primary care access and quality, with high admission rates indicating difficulty in accessing care in a timely fashion and poor care coordination or care continuity. ASH rates are also determined by other factors, such as hospital emergency department and admission policies, health literacy and overall social determinants of health. This indicator can also highlight variation between different population groups that will assist with DHB planning to achieve equity.

16.3 'under 20s able to access specialist mental health or addiction services within three weeks of referral' with 'follow up within seven days post discharge from an inpatient mental health unit'. Nationally, DHBs follow up with only two-thirds of people within seven days. The days and weeks following discharge are a high-risk time for suicide and non-fatal self-harm. International evidence shows that good planning for the transition from inpatient units to the community is critical in effectively supporting people with mental health conditions.

17 I have directed the Ministry of Health and the HQSC to further consult with health and disability sector experts on the revised indicators to ensure these are fit-for-purpose, and to report back to me in May 2021.

Publication of Health System Indicators framework

18 Public reporting of results will be through an interactive web-based reporting platform. The reporting will reflect the logic of the framework, from shared national priorities and indicators down to local actions and contributory measures.

19 A high-level national summary (by ethnicity) will be published on the website with public communication of the framework.

20 Eight out of the 10 indicators are ready for public reporting as a developmental dataset. The indicators will be defined as 'developmental' until they are tested and confirmed with the health and disability sector experts. I intend to publish the online national report when I publicly communicate the implementation of the new framework. The definition of the remaining indicators will be determined following consultation and further design work over March-April 2021.

21 Balancing measures and baselines will be added to the reporting platform over time following testing the Health System Indicators with the health and disability sector, establishing baselines, and assurance of good quality data.

22 Public reporting for the indicators, including the DHB results on local actions and contributory measures, will begin in December 2021 using data from the September quarter of 2021 (July-September 2021). Local actions and contributory measures for the indicators will be agreed with DHBs from the 2021/22 System Level Measures and DHB Annual Plans.

23 For this timeline to be achievable, I seek agreement from Cabinet to publicly communicate the implementation of the framework before 1 March 2021.

24 Table 1 outlines the proposed indicators mapped to Ministerial health priorities and identifies the intended release date.

Table 1: The proposed Health System Indicators

Ministerial health priority	Proposed indicators	Indicator description	Public reporting timeline
Improving child wellbeing	Immunisation rates for children at 24 months	Percentage of children who have all the recommended vaccinations by the time they are two.	National level (by ethnicity) from the date of announcement DHB results from December 2021
	Ambulatory sensitive hospitalisations for children (age range 0-4)	Rate of hospital admissions for children under five for an illness that might have been prevented or better managed in the community.	National level (by ethnicity) from the date of announcement DHB results from December 2021
Improving mental wellbeing	Follow-up within seven days post-discharge from an inpatient mental health unit	Percentage of people followed up within seven days after discharge from an inpatient mental health unit.	National level (by ethnicity) from the date of announcement DHB results from December 2021
	Access to primary mental health and addiction services	*New indicator to be finalised by May 2021.*	National level (by ethnicity) when finalised DHB results from December 2021
Improving wellbeing through prevention	Participation in the bowel screening programme	*New indicator to be finalised by May 2021.*	National level (by ethnicity) when finalised DHB results from December 2021
	Ambulatory sensitive hospitalisations for adults (age range 45-64)	Rate of hospital admissions for people aged 45 to 64 for an illness that might have been prevented or better managed in the community.	National level (by ethnicity) from the date of announcement and DHB results from December 2021
Strong and equitable public health system	Acute hospital bed day rate	Number of days spent in hospital for emergencies.	National level (by ethnicity) from the date of announcement and DHB results from December 2021
	Access to planned care	People who had surgery or care that was planned in advance, as a percentage of the original plan.	National level (by ethnicity) from the date of announcement and DHB results from December 2021
Better primary health care	Unmet need in primary care	Percentage of people who say they receive care from a GP or nurse when they need it.	National level (by ethnicity) from the date of announcement

			DHB results from December 2021
	People report being involved in the decisions about their care and treatment	Percentage of people who say they feel involved in their own care and treatment with their GP or nurse.	National level (by ethnicity) from the date of announcement DHB results from November 2021

Health System Indicators' role in system improvement

25 Publication of results is fundamental to achieving accountability through this proposal. A high-level national summary will be published online.

26 This framework will be a key lever for accountability across the health and disability system but will exist within a wider system of accountability shown in DHB performance reporting and other areas. Other important measurement and service improvement processes will continue to function following the implementation of this framework.

27 An example of this wider system of financial sustainability is the current suite of financial reporting. As part of the publication of the Health System Indicators, commentary on the importance of financial sustainability will be integrated, and a link to the current suite of financial reporting will be inserted.

Implementation

28 Full implementation of the framework will require significant sector engagement and technical development. This work is likely to take place for at least two months between March and April 2021 (based on a public announcement prior to March 2021). Table 2 outlines the key deliverables and indicative timelines for the implementation of the Health System Indicators.

Table 2: Key deliverables and timelines

Key deliverable	Indicative timeline
Testing of indicators with sector experts	From March 2021
Development of balancing measures and establishing baselines in collaboration with the health and disability sector	By June 2021
Communications with DHBs and primary health organisations (PHOs), community health service providers, professional bodies, and those currently involved in the System Level Measures (SLM) programme	From March 2021
Work with Māori stakeholders to ensure the framework prioritises and demonstrates equity	From March 2021
Training and support for those involved in establishing local level plans	From April 2021
Report back to Minister of Health on findings of consultation	By May 2021

Finalisation of the design of complete public facing reports	By June 2021
The full design of the process, including reporting mechanisms, instructions, timelines, and criteria for local planning	From June 2021
Maintenance, development and promotion of the Health Quality Measures New Zealand website	From June 2021
Release of first quarter of results (quarter 1 2021/22)	By December 2021

COVID-19 impacts

29 As earlier noted, implementation of the Health System Indicators framework has been significantly delayed, due to the ongoing COVID-19 response.

30 COVID-19 will also have a significant impact on some of the proposed indicators and consideration will need to be taken when establishing baselines for DHBs. For example, childhood hospitalisation rates decreased significantly during the lockdowns and using data from this quarter to set baseline would be misleading and will have flow on effects to future performance reporting.

31 A baseline for most measures will be set for the year ending December 2019, avoiding the impact in 2020 of COVID-19. This means that the first set of published data will be seven quarters later (September quarter 2021). I expect this data set to be more in line with the baseline than data from a 2020 baseline.

Retiring the national health targets

32 The national health targets have been in place since 2007. Over time, the targets have been adjusted to reflect changing priorities. Until June 2018, there were six national health targets, a full listing of the detail of those six measures is included in Appendix One.

33 The improved access to elective surgery health target was retired by a previous Minister of Health at the end of June 2018. The remaining five health target measures have continued to be included in DHB annual plans, and performance against them has been reported to the Ministry of Health each quarter. Under Ministerial direction, from August 2018, the Ministry of Health continued to update the health target results on the Ministry of Health website each quarter.

34 For the purposes of clear accountability, it is important to formalise a retirement date for the remaining five health targets within DHB accountability arrangements alongside introduction of the Health System Indicators framework.

35 Subject to your agreement, I would like to retire the health targets at the date of the implementation of the Health System Indicators framework, proposed to be 1 July 2021, with health target performance reported in line with the current reporting process concluding with the reporting for quarter 4 2020/21. This option means we will continue to meet our public commitments and the health targets will continue to be reported until the Health System Indicators framework is in place.

Financial Implications

36 There are no financial implications for this proposal if reporting is online only. All costs relating to implementing the Health System Indicators framework and publishing progress on them will be met through existing baselines.

Legislative Implications

37 There are no legislative implications arising from the recommendations in this paper.

Impact Analysis

Regulatory Impact Statement

38 The Treasury has advised a Regulatory Impact Statement (RIS) is not required for the recommendations in this paper as there are no legislative impacts.

Climate Implications of Policy Assessment

39 There are no implications on greenhouse gas emissions from the recommendations in this paper. Therefore, a Climate Implications of Policy Assessment (CIPA) is not required.

Population Implications

40 Improving equity is an important focus in all aspects of the health and disability system. This recognises that people have differences in health outcomes that are not only avoidable but unfair and unjust, and that people with different levels of advantage require different approaches to achieve equitable outcomes.

41 The implementation of the Health System Indicators has Treaty of Waitangi implications. Under schedule three of Te Tiriti, Māori are guaranteed the same rights as other New Zealanders. The ethnicity-based decomposition of the Health System Indicators will clearly demonstrate any inconsistency in health outcomes for Māori.

42 To better understand the scope and nature of equity concerns, indicator data will be disaggregated, where possible and appropriate, by factors such as sex, age (across all age groups including children, youth and older people), ethnicity, and level of deprivation.

43 Additionally, for each indicator, there will be at least one balancing measure of the distribution of that measure among different ethnic and socio-demographic groups. For example, a local intervention to decrease avoidable hospital admissions will not be considered a success if this intervention increases inequity between Māori and the non-Māori population.

44 Table 3 below summarises the impacts of this proposal for population groups that experience disparity in health outcomes.

Table 3: Summary of population analysis

Population group	How the proposal may affect this group
Māori and Pacific peoples	Equity for Māori, Pacific peoples, and other groups who experience disparity in health outcomes is a focus of the framework and is reflected in the choice of indicators. Indicators will be reported disaggregated by ethnicity, gender and New Zealand deprivation index. As the Māori population has a younger age structure than non-Māori or total population, data will be age-standardised where this is appropriate, and data is available. This is essential for indicators that have the general population as the denominator, ie, Ambulatory Sensitive Hospitalisations for 45-64-year olds and acute hospital bed days. Implementation of the framework by DHBs will present opportunities for improvement interventions at the local level with a focus on achieving equity, particularly for Māori and Pacific peoples. This will be ensured at the approval stage of planning, and by reflection on change over time to inform future improvement efforts. The Ministry of Health will hold DHBs accountable for outcomes and support them to work with iwi, hapū and their health system partners to address disparities in health outcomes.
Gender	Indicator results will be reported by male and female. This will enable all interested parties to monitor health outcomes and work to address inequities. As datasets are developed that contain results for other genders, this information will be added to the reporting.
Disabled people	People living with disability experience poorer health outcomes. Reporting Health System Indicators by disability status is not currently possible due to operational datasets lacking information about disability status, and not having the level of detail required to inform improvement initiatives (i.e., disability due to mental vs physical impairment, congenital vs acquired conditions, level of support required).

Human Rights

45 The proposals outlined in this paper are consistent with the New Zealand Bill of Rights Act 1990 and the Human Rights Act 1993.

Consultation

46 The following agencies were consulted on this paper: The Treasury, the Department of the Prime Minister and Cabinet, and the HQSC.

47 The Ministry of Health will continue to engage with The Treasury on the implementation of this framework.

48 The Ministry of Health has provided an initial briefing to a selection of key health and disability sector leaders about the Health System Indicators framework to gauge their responses. Overall, there is positive feedback from the sector groups briefed to date.

Communications

49 Subject to your agreement, I would publicly communicate the implementation of the Health System Indicators framework in a media release prior to 1 March 2021.

50 Following public communication of the Health System Indicators framework, the Ministry of Health and the HQSC will engage with the health and disability sector, in particular DHB and primary care clinical leaders, to finalise the indicators and the implementation of the framework.

Proactive Release

51 This Cabinet paper will be publicly released following the media release in March 2021. The release is subject to redactions as appropriate under the Official Information Act 1982.

Recommendations

The Minister of Health recommends that Cabinet:

1. **note** that in December 2019, Cabinet agreed to a new framework for publicly reporting health system performance [CAB-19-MIN-0664 refers]

2. **note** that the new framework will be known as the 'Health System Indicators'

3. **note** that an initial briefing has been provided to a selection of key sector leaders about the Health System Indicators framework, and feedback has been positive so far

4. **note** that the Ministry of Health and the HQSC will further consult with health sector experts on the revised indicators to ensure these are fit-for-purpose and report back to me in May 2021

5. **agree** for the Minister of Health to make final decisions on the design and implementation of the Health System Indicators by the end of June 2021

6. **agree** to publicly communicate the implementation of the Health System Indicators framework as our new way of reporting health and disability system performance

7. **agree** to retire the national health targets at the date of the implementation of the Health System Indicators.

Authorised for lodgement

Hon Andrew Little
Minister of Health

Appendix 1: Definition of the National Health Targets

The national health targets have been in place since 2007. Over time, the targets have been adjusted to reflect changing priorities. The current six national health targets are defined as below.

1. Shorter stays in emergency departments. Target: 95 percent of patients will be admitted, discharged or transferred from an Emergency Department within six hours.

2. Improved access to elective surgery. Target: An increase in the volume of elective surgery by an average of 4,000 discharges per year – measure retired in June 2018.

3. Faster cancer treatment. Target: 85 percent of patients 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.

4. Increased immunisation. Target: 95 percent of eight-month-olds have their primary course of immunisation at six weeks, three months, and five months, on time.

5. Better help for smokers to quit. Target: 90 percent of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months.

6. Raising healthy kids. Target: 95 percent of obese children identified in the Before School Check programme will be offered referral to a health professional for clinical assessment and family-based nutrition, activity and lifestyle interventions.

Document 12

MINISTRY OF HEALTH
MANATŪ HAUORA

Briefing

Health System Indicators Framework – implementation approach and sector feedback

Date due to MO:	31 May 2021	**Action required by:**	N/A
Security level:	IN CONFIDENCE	**Health Report number:**	20211225
To:	Hon Andrew Little, Minister of Health		

Contact for telephone discussion

Name	Position	Telephone
Robyn Shearer	Deputy Chief Executive, Sector Support and Infrastructure	S9(2)(a)
Jess Smaling	Associate Deputy Director-General, DHB Performance and Support	S9(2)(a)

Minister's office to complete:

☐ Approved ☐ Decline ☐ Noted

☐ Needs change ☐ Seen ☐ Overtaken by events

☐ See Minister's Notes ☐ Withdrawn

Comment:

Health System Indicators Framework – implementation approach and sector feedback

Security level:	IN CONFIDENCE	**Date:**	31 May 2021
To:	Hon Andrew Little, Minister of Health		

Purpose of report

1. This report provides feedback to you from targeted health sector engagement on the new Health System Indicators Framework, the high level measures and the plan for implementation [SWC-21-MIN-0002 refers].

Summary

2. The Health System Indicator Framework was approved on 22 February 2021 by the Cabinet Social Wellbeing Committee for publicly reporting health system performance. The Ministry of Health (the Ministry) is working towards a 1 July 2021 implementation date.

3. As requested in May 2021, targeted feedback was sought from the sector. This feedback indicates:

   a. There was support for the Health System Indicators Framework, building on the philosophy of the system level measures programme. Continuous quality improvement grounded in improvement science, informed by data and co-designed with the sector, with a focus on system integration and equity were all raised as essential components.

   b. Publishing the initial measure set at the national level on 1 July 2021 as a tool to monitor the system during transition was considered acceptable but some limitations with the measure set were noted. There was strong support for developing the framework and measures with the sector over 2021/22. This should include a focus on equity for Māori. The sector viewed further engagement positively.

   c. Two measures in the initial set require further development before they can be publicly reported. This is due to both limitations in data completeness and the interpretation of the measures. These measures include both access to primary mental health and addiction services, and participation in bowel screening.

Recommendations

We recommend you:

a) **Agree** that, pending your announcement of the health system indicators, the baseline data at the national level (2019 data) for the ten measures be publicly reported online from date of announcement. **Yes/No**

b) **Note** that the national health targets will be retired at the date of implementation of the Health System Indicators.

c) **Agree** that the framework structure, processes and measures are developed and refined over 2021/22 alongside early implementation of the health and disability system reforms. **Yes/No**

Robyn Shearer
Deputy Chief Executive
Sector Support and Infrastructure
Date:

Hon Andrew Little
Minister of Health
Date:

Health System Indicators framework

Purpose and summary

1. This report provides feedback to you from targeted health sector engagement on the new Health System Indicators Framework and its implementation [SWC-21-MIN-0002 refers].

2. The Health System Indicators Framework is a new approach to health system performance measurement. The framework is premised on shared accountability. The Government sets high-level goals for the system; the Ministry and the Health Quality and Safety Commission (HQSC) develop high level measures for those goals with input from the health sector; and local providers work with input from local consumers to agree what local actions are needed to contribute to the high-level goals.

3. A two-phased approach to implementation is proposed to align with the health and disability sector reform agenda.

4. In phase one, baseline data for ten high level measures (that are already routinely reported) representing the Government's five priorities for the health system are publicly reported. Publishing baseline data for these measures, and tracking it quarterly, demonstrates to the public and the Government that health services continue to be delivered, and performance monitored, as the health reforms are implemented.

5. The Ministry continues to work towards a 1 July 2021 implementation date for the Health System Indicators. Phase one runs from 1 July 2021 to 30 June 2022.

6. In phase two, the full Health System Indicator Framework, including local contributory measures, is co-produced alongside implementation of the health system reforms over 2021/22. This development time is important to establish the necessary processes, measures and structures for the new framework, for ensuring equity is built in and to develop strong working relationships between the centre and local providers.

7. The new framework is expected to be developed by 1 July 2022.

Key findings

8. Overall, there was support for the Health System Indicator Framework approach of building on the System Level Measures (SLM) programme philosophy. The sector values a focus on co-design, integration, improvement science and support for quality improvement.

9. The initial set of measures was considered a reasonable starting point to monitor the system during a year of transition, although some limitations were noted. This included no visibility of youth or support for smoking cessation. It is recommended to further develop the measures reporting access to primary mental health and addiction services and participation rates in bowel screening over 2021/22.

10. There was strong interest in working with the Ministry and HQSC to co-produce the framework over 2021/22. This includes developing the measure set to ensure it includes measures with a focus on equity, primary care and prevention. For further information, see Appendix One.

How is the Health System Indicator Framework different to targets?

11. The framework was developed in partnership by the Ministry and HQSC to create a more flexible and devolved approach to performance management, focused on learning rather than control. The new approach explicitly links integration at a local level through supporting local relationships and health system improvement.

12. It proposes a co-operative trust-based approach with the following key elements:

    a. The Ministry[1] and HQSC identify high level measures that match Government priorities.

    b. Locality networks[2] work with their local population to co-produce locality plans that address local issues, and tailor services to local needs, while contributing to improvement on high level measures.

13. The new framework is not just public reporting of a set of measures but a learning system supporting improvement. It is important that we tell a more complete story of health system performance that supports consistent improvement. The new framework empowers hospital and primary health care clinicians, managers and analysts to develop local actions for improvement; and to use appropriate contributory measures to tell a local data story connected to the national story that is publicly reported. The emphasis will be on continuous improvement of current performance with a strong focus on equity.

14. Devolved improvement activities and actions with consideration for unique local contexts is linked to both accountability at the locality and regional levels, and national improvement.

What is the Health System Indicator Framework?

15. The new framework recognises the importance of collaboration; of mutually agreed aims; and of using a range of measures to report and improve on rather than focusing on a single target that can lose its improvement focus as it becomes a target to hit.

16. It aligns with, and builds on, the established SLM programme philosophy of collaboration and shared accountability for continuous improvement of health services, consumer experience and equitable care.

17. The framework uses two different types of measures:

    a. 'High level measures': these are aligned with high level goals to help understand how the health system is performing. What they measure is high-level and would be difficult for providers to find work-arounds that make their performance appear better than it actually is.

    b. 'Contributory measures', these measure the impact of local initiatives where improvement not only serves the specific community/locality, but also leads to improvement on the high level measure.

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[1] In the new structure, this is likely to be undertaken jointly by the Māori Health Authority and Health NZ as the agencies who commission services, oversee performance and lead improvement.

[2] These provide a range of primary and community services. Communities, along Iwi-Māori partnership Boards will be involved in developing locality plans that set priorities for local health services.

18. Table one shows how one high level measure, the acute hospital bed day rate, sits within a broader suite of measures.

19. Acute hospital bed day rate aims to measure and manage demand for acute inpatient services. The intention is to support care that focuses on integration between community, primary and secondary care in order to focus on planned rather than acute care. Acute readmissions are monitored to ensure that patients are not being discharged too early and contributory indicators include emergency department length of stay.

Table 1: A worked example of the new framework: acute hospital bed day rate

Measure type	Title	Description
High level measure	Acute hospital bed day rate	Days spent in hospital for emergencies
Example contributory measures	Acute readmissions	Ensure patients receive joined up care (between primary and secondary health and social care service) to avoid readmission
	Emergency department length of stay	Ensure patient journey through acute care is efficient
	Inpatient average length of stay for acute admissions	Ensure patients only stay in hospital as long as they need to. This is also a balancing measure to ensure that patients are not being discharged too early in order to improve bed day rate, and bouncing back into hospital
	Ambulatory sensitive hospitalisation	Reducing acute admissions that may be preventable through early access to primary care

20. As Table one shows, the high level measures are only one part of a measurement and improvement framework. This reduces the weight put on single measures and limits the risk of over-interpretation. The framework requires integration between services for success and reducing the incentive to game.

21. The high level measures are aligned with government priorities and are intended to change as priorities and goals change.

Implementing Health System Indicators Framework during health reform

Phase one: report measures to monitor health system performance over 2021/22

22. Eight of the twelve measures in the new framework are already routinely used by DHBs and the data is already publicly available. Table 2 shows the proposed measures, their alignment with Government priorities and whether the data are already publicly available.

Table 2: Proposed measure

Government priority	Proposed measure	Data publicly available?
Improving child wellbeing	Immunisation rates for children at 24 months*	Yes[3]
	Ambulatory sensitive hospitalisations for children (age range 0-4)*	Yes[4]
Improving mental wellbeing	Follow-up within seven days post-discharge from an inpatient mental health unit*	MHA KPI website
	Access to primary mental health and addiction services (requires further development)	
Improving wellbeing through prevention	Ambulatory sensitive hospitalisations for adults (age range 45-64)*	Yes[4]
	Participation in bowel screening programme (requires further development)	
Strong and equitable public health system	Acute hospital bed day rate*	Yes[5]
	Access to planned care*	Yes[6]
Better primary health care	People report they can get primary care when they need it*	Yes[7]
	People report being involved in the decisions about their care and treatment*	Yes[4]
Financially sustainable health system	Annual surplus/deficit at financial year end	Yes[8]
	Variance between planned budget and year end actuals	

* denotes routinely used measure.

What will be reported?

23. The first public report will made be available from the date of announcement, reporting the logic and rationale of the framework, and the high level measures and their baseline results at the national level and by ethnicity. Appendix Two shows a screenshot from HQSC web site.

24. Public reporting for the indicators, including DHB results, will begin in December 2021 and use data from the September quarter of 2021 (July–September 2021).

25. The two financial indicators require final audited accounts for reporting. The first report will show data for 2019/20, the first update is likely to be in February 2022 with accounts for the 2020/21 financial year.

Phase two: co-produce the Health System Indicator Framework

[3] https://www.health.govt.nz/our-work/preventative-health-wellness/immunisation/immunisation-coverage/national-and-dhb-immunisation-data
[4] https://nsfl.health.govt.nz/accountability/performance-and-monitoring/data-quarterly-reports-and-reporting/ambulatory-sensitive
[5] https://public.tableau.com/profile/hqi2803#!/vizhome/Healthsystemqualitydashboard12Feb2021/1_Home
[6] https://www.health.govt.nz/our-work/hospitals-and-specialist-care/planned-care-services/planned-care-interventions
[7] https://www.hqsc.govt.nz/our-programmes/health-quality-evaluation/projects/atlas-of-healthcare-variation/health-service-access/
[8] https://www.health.govt.nz/new-zealand-health-system/key-health-sector-organisations-and-people/district-health-boards/accountability-and-funding/summary-financial-reports/dhb-sector-financial-reports-2019-2020

26. The second phase proposed to occur over 2021/22 is to co-produce the Health System Indicator Framework alongside initial implementation of the health system reforms. The approach proposed requires, and supports, the development of strong working relationships between the centre (Ministry, HQSC and Health NZ) and local communities and providers.

27. Activity includes: sector engagement with a range of stakeholders including health providers, Māori/Iwi partnership Boards, consumers and clinicians; establishing processes for locality planning and measurement; processes around consumer advisory groups; establish processes for approval and monitoring of plans and execution (Health NZ/the Ministry); measure development to create a coherent and robust set of measures; and communications. HQSC will lead development of the reporting platform and maintaining the measures library.

Sector engagement

28. Key themes of the feedback from the following groups are included: Te Tumu Whakarae, DHB General Managers Planning and Funding, Pacific perspectives, senior Pacific academic, General Practice NZ National Leader's forum, PHO Clinical Leaders, Directors of Allied Health, trusted DHB Chief Executives, the Office of Disability Issues, HQSC Integrated Advisory Group and Treasury. Appendix One refers to a summary of the feedback received.

29. The following groups were engaged with in 2020: DHB Chief Executives, DHB Chief Medical Officers, DHB General Managers Planning and Funding, Te Tumu Whakarae, PHO Chief Executives, PHO Clinical Leaders and HQSC's Integrated Advisory Group.

Measures that require further development

30. There are two measures that are not recommended to be included in the Health System Indicator reporting for 2021/22. These are access to primary mental health and addiction services and participation in the bowel screening programme. Health System Indicator reporting needs a stable baseline at both the national and DHB level to allow tracking of change over time. Data will be reported on a rolling 12-month average and be updated quarterly. This means a full years' worth of data is required for the baseline. For the clinical measures, the baseline will be 2019, given the impact of COVID-19 on health services in 2020. Neither of these measures have nationally complete data for 2019.

Access to primary mental health and addiction services.

31. Contracting for the new primary mental health and addiction services is split equally between the Ministry, who directly contracts with NGOs for the delivery of kaupapa Māori, Pacific and youth primary mental health and addiction services, and contracts via DHBs with integrated primary mental health and addiction services. Most of these providers have no existing systems for reporting data to the Ministry. For services contracted via DHBs, a new reporting system will be functional from 1 July 2021 but there is no historical baseline data. For the services contracted directly by the Ministry, most of which have not yet been implemented, reporting systems need to be developed. It will take time for their reporting to mature to a standard where it can withstand public reporting and media scrutiny.

32. The philosophy of the Health System Indicator Framework reporting is that DHBs are accountable for local activity to increase access. It is difficult to have a clear line of sight with the split contracting model.

33. More broadly, it was noted that this is not a measure of integration or the 'system', rather it is specific to a primary mental health funded programme.

34. It is recommended that a measure for mental health, that fits with the new structures implemented in the HDSR reforms, be developed with the sector over 2021/22. In the meantime, reporting systems will be embedded, and baseline data captured.

Participation in the National Bowel Screening Programme (BSP)

35. While the aligned government priority is 'improving wellbeing through prevention', the BSP is not a measure of prevention, rather it looks at early detection. BSP itself does not focus on prevention or public health interventions such as healthy eating.

36. This is not a whole of system measure. The measure is calculated as the percent of those invited to participate who complete the test. This is not a measure of population 'national participation', rather it is measure of uptake once people have been invited. Most participants (95 percent) do not have contact with a health professional and their GP will only know when an individual has participated in the programme by receiving the screening test result. GPs have no visibility when an individual is invited or if their patients either opt out or don't participate.

37. BSP invites the eligible cohort in a DHB over a two-year timeframe. This means there will not be a national coverage rate until two years after the last DHB has implemented. Based on current timelines this will be in December 2023.

38. The 2019 data represents seven DHBs at various stages of implementation. While this is a useful thing to monitor, it should be part of a suite that includes population participation. Reporting uptake of those invited in a selection of DHBs requires different framing.

39. It was suggested that a composite screening measure including, for example, cervical, breast and possibly even cardiovascular risk assessment (CVDRA) may be a better option.

Announcing the new framework and retiring the health targets

40. Health target performance continues to be reported by the Ministry as part of meeting public commitments. The Cabinet paper [CAB-21-MIN-0024] agrees that the health target performance reporting will be retired at the date of the implementation of the Health System Indicators Framework. This would mean health target performance reporting concludes in quarter four 2020/21. DHBs already have planned activities for 2021/22 and will continue to be held to account pending structural changes from July 2022.

Equity

41. The implementation of the Health System Indicators has Treaty of Waitangi implications. Under article three of Te Tiriti, Māori are guaranteed the same rights as other New Zealanders. All non-financial measures will be stratified by ethnicity, which will clearly highlight differences in health outcomes for Māori. Further disaggregation by age and gender will help identify the largest equity gaps.

42. The new Māori Health Authority will be involved in agreeing on priorities with Health New Zealand and the locality networks. Locality network alliances will involve Māori providers, iwi and natural groupings to ensure that local activity, supported by local measures, focusses on areas of importance to Māori.

43. Each indicator will monitor change by ethnicity and narrowing the gap will be a focus. An intervention will not be considered a success if it worsens or does not improve differences between Māori, non-Māori and non-Pacific populations.

Consultation

44. This report has undergone consultation with HQSC and been shared with Treasury.

Next steps

45. We await your instructions on announcing and publicly reporting the Health System Indicator Framework.

Appendix One: Key themes from sector engagement

Equity for Māori

- The importance of Māori involvement in developing the framework so that it improves equity of outcomes was raised multiple times.
- There needs to be focus on improving services for Māori health. This should include both kaupapa Māori and mainstream providers and be based on the evidence/data – this is what we need to do to achieve equity. Providers should be held to account for achieving certain outcomes.
- How will equity be prioritised? How will the framework be Te Tiriti based? Will prevention measures for Māori be prioritised? Is there a way in the reporting to target and be specific for improvements in Māori, to move the set away from measures of equality and towards measures of equity? This links with other discussions around the need for better primary care data.
- There were questions around the role of the Māori Health Authority in measuring and monitoring improvement.

The framework

- Many groups talked about developing comprehensive metrics, with the high level measures, the connected contributory measures, the rationale and the contribution that different people can make. Measures need to represent activity done throughout the system and no one agency should be penalised for events that occur throughout the network. There was support for a multi-disciplinary approach to accountability.
- There were questions on on-going sector governance of the programme.
- Ensuring that groups have the appropriate systems and processes to take an improvement approach was raised. Does the workforce have the skills and capabilities to drive the change? For example, for smoking cessation, does the workforce have enough capability in motivational interviewing? Or for immunisation, is the workforce sufficiently prepared to counter anti-vaccination information?

Data

- The importance of knowing your data is a key recommendation from the Pacific window 2021 report developed with Pacific perspectives and HQSC. The Health System Indicators framework is an opportunity to build on this, specifically around mandating access to and use of data with benchmarking and data standards.
- The lack of primary care data is a limitation. Addressing access to data is a critical part of what the HDSR reform would deliver.
- There is a lack of capability in the sector for analysis and the sector needs upskilling. National equity analyses are important ways to empower local providers to act; groups liked that all analyses will be presented by ethnicity. Providing data at the DHB, PHO and locality levels was suggested to ensure the same approach to representing equity and bringing the data intelligence as close to the quality improvement 'engine' as possible.
- Limited disability disaggregation in the Health System Indicators Framework was noted. The ability to disaggregate the patient experience survey results was seen as a good start to work on.

Accountability

- There needs to be consequences for not achieving equity.
- Why are there different sets of indicators for monitoring the performance of the health sector, e.g. SLM and annual plans?
- Important to have accountability in the ethos alongside improvement.
- What will the lines of accountability be for the framework (regional, provider, localities)? It is important that the framework focuses on those who are responsible.

Funding

- Where will funding sit in the future? The tension in the current SLM programme with funding aligned to PHOs but the work requiring a whole of system response was noted. It was suggested that removing the financial incentive was a good thing and likely to enhance a system-wide approach.
- The counterview raised was that the SLM programme has always been led out of primary care and funding for quality improvement is critical for it be able to gain traction. Some noted that if you want to effect change, there needs to be funding. Some noted that without payment they wouldn't be able to get data from primary care.

Measures

- Most groups wanted the opportunity to discuss the measures further, although excluding the primary mental health and bowel screening measures, there were no showstoppers. Some groups thought the measures were logical and sensible. It was recommended that framing to the sector needs to be clear that the initial measure set is for one year only and that the Ministry and HQSC are open to working with them to develop the measure set over 2021/22.
- There were some comments around the link between the Government priorities and the measures. For example, the measures to improve wellbeing and prevention (Ambulatory Sensitive Hospitalisations (ASH) and bowel screening participation) do not have a wellbeing or prevention focus. ASH focuses on improved management in primary care (to reduce hospital admissions) and bowel screening focuses on early detection. There was general support for both ASH high level measures as they focus on primary care access and quality in the management of a specific set of conditions.
- The impact of the wider determinants of health on improving against some indicators (specifically child ASH) was raised. It was suggested to think about the overall measures, contributory measures and links to social and other agencies. Another view was that this work should focus on health and what is in health's scope.
- For Māori equity a focus on non-communicable diseases, morbidity and mortality measures, such as improving cancer outcomes are important. Improving life expectancy is a 20 – 30-year journey. Amenable mortality can be a good measure for this. This indicator was also noted as relevant for people with intellectual disabilities who have much shorter life expectancy.
- For Pacific, measures that focus on children, prevention and primary care were key.
- Are there other measures for primary care? The framing of 'better primary health care' implies that primary care is not currently performing well.

- There could be a measure of unmet need in secondary care to sit alongside unmet need in primary care, for example using the newly added question in the New Zealand Health Survey. There was support for the patient experience survey questions.
- Referral from primary care and decline rate is not captured but could be useful in the context of cost and demand (financial measures).
- The measure 'babies living in smoke free homes' was identified as an important driver of integration.
- Workforce measures to grow the Māori workforce could be potentially transformational but need time to establish. Cultural competence measures should be included.
- Workforce measures were suggested several times as useful additions to the financial indicators. These could include workforce wellbeing or safe staffing levels.
- Ensuring that the whole workforce is considered in the framework, increasingly important with changing models of care.
- The financial measures will need changing once DHBs are disestablished. There was interest in developing measures of value.
- Keen to move to outcomes-based reporting and away from 'widget' counting.
- For equity need to see a longer time frame for planning and change.
- The New Zealand Disability Strategy has an action to increase access to health services and improve outcomes for disabled people with a specific focus on people with learning / intellectual disabilities. This links well with the indicator that asks about people's ability to access primary care (and can be split by disability).

Appendix Two: Example of online reporting

Proposed reporting from 1 July 2021, national results using data for 2019. The webpage is interactive, when a measure is selected (as in the yellow highlight), data showing results over time and by ethnicity are displayed.

Health System Indicator Government priority	Data to December 2019*	Change will be reported as:
Improving child well-being	**20,240** avoidable stays in hospital for children under 5	X fewer avoidable stays in hospital for children under 5
	14,146 two year old children were fully immunised (92% of children)	X more two year olds are fully immunised
Improving mental health	**7,264** people were followed-up within seven days of leaving inpatient mental health services (65%)	X more people were followed-up within seven days of leaving inpatient mental health services (xx%)
Improving well-being through prevention	**48,217** avoidable stays in hospital for people aged 45-64	X fewer avoidable stays in hospital for people aged 45-64
Strong and equitable public health system	**146,246** people had surgery or care as planned (3% more than planned)	X more people had surgery or care as planned
	2,067,733 days spent in hospital for emergencies	X fewer days spent in hospital for emergencies
Better primary health care	**84%** of people can get care when they need it	X% more people can get care when they need it
	82% of people feel involved in their care and treatment	X% more people feel involved in their care and treatment
Financially sustainable health system	Annual deficit is **2.80%** of revenue excluding one-offs, **5.70%** of revenue including one-offs **	The annual deficit and a percentage of revenue has improved/declined by X percentage points excluding one-offs, and X percentage points including one-offs
	Actual deficit result is worse than the approved plan/budget by **$38m(12.0%)** excluding one-offs and by **$488.8m(154.3%)** including one-offs ***	These indicators are reported annually and represent the actual year-end position versus plan/budget

*Financial year end 2019/20 is applied to finance indicators. **One-offs are Holiday Act provisions and unfunded COVID-19 impacts. ***This excludes Canterbury DHB as the Plan/Budget was not approved.

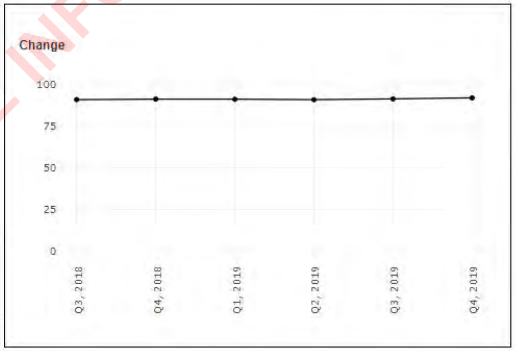
In detail

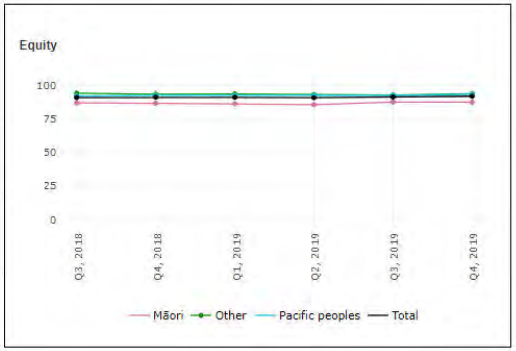
Measure

Percentage of children who have all the recommended vaccinations by the time they are two

Value of measure for latest period:
3 months to end Dec 2019
92%

Baseline period (TBC)





Document 13

Briefing

Health System Indicators Framework – consultation findings

Date due to MO:	8 December 2021	**Action required by:**	N/A
Security level:	IN CONFIDENCE	**Health Report number:**	20212680
To:	Hon Andrew Little, Minister of Health		

Contact for telephone discussion

Name	Position	Telephone
Robyn Shearer	Deputy Chief Executive, Sector Support, and Infrastructure	S9(2)(a)
Jess Smaling	Associate Deputy Director-General, DHB Performance and Support	S9(2)(a)

Minister's office to complete:

☐ Approved ☐ Decline ☐ Noted

☐ Needs change ☐ Seen ☐ Overtaken by events

☐ See Minister's Notes ☐ Withdrawn

Comment:

Health System Indicators Framework – consultation findings

Security level:	IN CONFIDENCE	**Date:**	8 December 2021
To:	Hon Andrew Little, Minister of Health		

Purpose of report

1. This report provides feedback to you on the findings from sector consultation on the Health System Indicators framework, undertaken over October and November 2021.

Summary

2. The Health System Indicators Framework was approved on 22 February 2021 by the Cabinet Social Wellbeing Committee as a new system for publicly reporting health system performance, with the public announcement made on 6 August 2021.

3. Sector consultation was obtained via five virtual workshops attended by more than 100 people in total. Each workshop had focused discussion on one or two of the Government priorities for health. The goal was to test the high-level indicators for their suitability to support local improvement. This included the two developmental indicators (access to primary mental health and addiction services and participation in the bowel screening programme). Two new indicators for the financially sustainable health system priority are proposed. These would replace the current indicators that are focused on district health board deficits.

4. In most cases, the high-level indicators were supported, where they were not, alternatives are recommended.

Recommendations

We recommend you:

a) **Agree** that eight of the high-level system indicators are retained as they are. **Yes/No**

b) **Agree** that: **Yes/No**

i) the developmental indicator 'access to primary mental health and addiction services' is reported from 1 July 2022.

ii) initial reporting is limited to data from Integrated Primary Mental Health and Addiction services, expanding to all providers as the NGO dataset is validated and a time series is established.

c) **Agree** that for the priority of 'improving wellbeing through prevention', the high-level indicator is reducing bowel cancer incidence, with participation in the bowel screening programme a mandatory contributory measure. Reporting to start from 1 July 2022. **Yes/No**

d) **Agree** that for the priority of a financially sustainable health system, the two high-level indicators reported from 1 July 2022 are: **Yes/No**

- Contracted FTE per 100,000 population.
- Expenditure on assets repairs and maintenance as a percent of total net book value of assets.

Robyn Shearer
Deputy Chief Executive
Sector Support and Infrastructure
Date:

Hon Andrew Little
Minister of Health
Date:

Health System Indicators framework

Purpose and summary

1. This report provides feedback to you from health sector consultation on the new Health System Indicators (HSIs) framework.

2. The HSIs Framework is a new approach to health system performance measurement. The framework is premised on shared accountability. The Government sets high-level goals for the system; the Ministry of Health (the Ministry) and the Health Quality and Safety Commission (HQSC), to develop high level measures for those goals with input from the health sector; and local providers networks work with whānau and local communities to agree what local actions are needed to contribute to the high-level goals.

3. During 2021/22, development of the full Health System Indicator Framework, including finalising the developmental indicators and developing contributory and balancing measures is underway. The new framework is expected to be developed by 1 July 2022.

Key findings

4. Sector consultation was obtained via five virtual workshops, attended by more than 100 people in total. Each workshop had focused discussion on one or two of the Government priorities for health. The goal was to test the high-level indicators for their suitability to support local improvement. This included finalising the two developmental indicators (access to primary mental health and addiction services and participation in the bowel screening programme). Two new indicators for the financially sustainable health system priority are proposed. These would replace the current indicators that are focused on district health board (DHB) deficits.

5. In most cases, the high-level indicators were supported, where they were not, alternatives are recommended.

Background

6. Implementation of the HSIs framework requires the following deliverables to be completed over 2021/22:

    i. Testing the indicators with sector experts
    ii. Developing balancing measures
    iii. Report back to the Minister on the findings of consultation
    iv. Work with Māori stakeholders to ensure the framework prioritises and demonstrates equity
    v. Training and support for those involved in establishing local improvement plans
    vi. Finalising the process, including reporting mechanisms, instructions, timelines, and criteria for local planning.

7. This report meets deliverable iii, summarising the feedback from deliverables i and ii.

8. This builds on targeted feedback that was sought from the sector at your request, in May 2021. That feedback indicated:

i. Support for the HSIs Framework. Continuous quality improvement grounded in improvement science, informed by data, and co-designed with the sector, with a focus on system integration and equity were all raised as essential components.

ii. Support for developing the framework and measures with the sector over 2021/22. Limitations of the indicator set were noted. This included no visibility of youth or support for smoking cessation. It was recommended to further develop the indicators reporting access to primary mental health and addiction services and participation rates in bowel screening over 2021/22.

Feedback obtained via five virtual workshops

9. Five sector workshops structured around the Government priority areas were held over October and November 2021. The priorities of 'improving wellbeing through prevention' and a 'strong and equitable public health system' were combined into one workshop given the high overlap between these areas.

10. A key feature of the HSIs framework is that regional offices work collaboratively with their health sector partners[1] to develop improvement plans containing local actions with associated contributory and balancing measures. A guide for using the HSIs framework to improve performance is being developed as part of deliverable v. and vi.

11. The workshops built on previous sector feedback on the high-level indicators but sought detailed feedback on improvement actions for each indicator, in keeping with the spirit of the HSIs framework which is that it is co-designed with the sector. The focus was on developing an intervention logic or theory of change for each high-level indicator by identifying actions with a line-of-sight for improvement for each indicator. The resulting intervention logics are expected to be the engine room for local improvement and are expected to better support improvement, share knowledge of what works and promote activity with a grounding in evidence.

12. Workshopping the intervention logic for each indicator served multiple purposes including:

i. Allowing each high-level indicator to be tested to confirm it was sufficiently broad to allow system-wide improvement activities to logically sit under it

ii. Identifying actions, questions and measures that could be employed locally for each high-level indicator

iii. Allowing the concept of mandating certain contributory measures to be tested (the idea being that certain improvement activity may be essential to be implemented nationwide)

iv. Giving valuable feedback on the barriers and enablers for improvement for each HSI

v. Socialising the HSIs framework and the concept of using an intervention logic as a basis for planning, both internally in the Ministry teams and externally

[1] **Work is expected to occur at a locality level once the new system locality settings are in place. In the interim a variety of approaches may be taken that build on existing DHB arrangements with their local partners.**

vi. Providing us with important feedback on how the HSIs framework is viewed by a many different parts of the health sector (for example, experts from cancer, mental health, primary care, child health etc). It also gave Ministry officials valuable insight into the real world of clinical activity and population health, its complexity and the challenges and opportunities faced.

13. Workshop attendees[2] reviewed draft intervention logics for each high-level indicator. Each logic includes key constructs, actions or questions and associated contributory and balancing measures, see Table One for definitions. The constructs and improvement actions were not developed to be an exhaustive list or prescriptive; rather to act as a supporting tool to prompt a systematic approach to improvement. The intervention logics are expected to be added to and improved iteratively.

Table One: Intervention logic terms and definitions

Term	Definition
High-level indicator aim	This is the desired outcome of each high-level indicator, for example, more people have shorter waiting times with an associated appropriate ethnicity response.
Main construct	These are factors that are known to impact on the high-level indicator.
Action or question	These are quality improvement activities that can influence the main construct or further questions that can be explored to identify improvement opportunity.
Contributory measure	These are measures that are used to monitor local progress towards quality improvement activities identified in the actions. There should be a clear line of sight between the action and the contributory measure.
Balance measure	These are measures that are tracked to ensure that improvement in one area is not negatively impacting on another area.
Milestone	This is the local goal for improvement. It is a number that improves performance from baseline for either total population, Māori, or other vulnerable population group. If there is an equity gap the milestone must reduce this gap.

14. To develop the intervention logics, a two-stage process was applied. First, Ministry advisors, managers and clinicians produced a draft intervention logic based on their knowledge of current and previous improvement activities, programmes, and plans. This was used to stimulate discussion at the workshops facilitated by the HSIs programme manager and clinical lead. These were run virtually despite a preference for face-to-face

[2] **Each workshop was attended by between 20 - 30 people comprised of representatives from DHBs, PHOs, the Ministry of Health, the Health Quality & Safety Commission, national organisations, NGOs, Treasury and the Transition Unit. Different experts were invited for each priority, with some people attending more than workshop.**

workshops, because of the restrictions imposed by the COVID-19 response. This enabled engagement with clinicians from across the country including Auckland.

Key findings

15. The sector participants generally viewed the intervention logics as a useful tool for quality improvement. They prompted constructive and wide-ranging discussion on areas for system and local improvement, the importance of focusing on equity, and the changes that COVID-19 has had and is continuing to have on the health system.

16. These elements emerged as being important to multiple HSIs. The first five are aligned to the key system shifts of the health reforms.

    i. Te Tiriti principles.
    ii. Integrated primary and community services to support people to stay well in communities.
    iii. Equitable access to emergency or specialist care.
    iv. Digital services provide more care in people's homes.
    v. Health and care workers will be valued and well-trained ensuring we have enough trained people, resourced to provide better services for our communities.
    vi. Better use of data to inform opportunities for improvement.
    vii. Culturally safe services.
    viii. COVID-19-related disruption.

17. Appendix One contains a summary of the discussion across these themes, with potential improvement actions.

The HSI indicator set

18. Throughout the workshops, the importance of the framework rather than the specific high-level indicators was emphasised. Key contributory measures were viewed as drivers of improvement and ways to 'fill' gaps in the high-level indicator set, for example, youth health or reducing smoking. Setting mandatory contributory measures was viewed positively to promote consistency and reduce variation.

19. The intervention logic confirmed that eight of the twelve high-level indicators (in bold) provided scope for a wide range of improvement activity. Four indicators (in italics) required further development: the two developmental indicators and the two financial indicators.

Government priority	High-level indicator
Improving child wellbeing	**Immunisation rates for children at 24 months**
	Ambulatory sensitive hospitalisations for children (age range 0-4)
Improving mental wellbeing	**Under 25s able to access specialist mental health services within three weeks of referral**
	Access to primary mental health and addiction services (developmental)
Improving wellbeing through prevention	**Ambulatory sensitive hospitalisations for adults (age range 45-64)**
	Participation in bowel screening programme (developmental)
	Acute hospital bed day rate

Government priority	High-level indicator
Strong and equitable public health system	**Access to planned care**
Better primary health care	**People report they can get primary care when they need it**
	People report being involved in the decisions about their care and treatment
Financially sustainable health system	*Annual surplus/deficit at financial year end*
	Variance between planned budget and year end actuals

The developmental indicators

Access to primary mental health and addiction services (Access and Choice)

20. The workshop discussion centred on the indicator definition and intervention logic.

The indicator and definition.

21. As noted in the briefing Health System Indicators framework – implementation approach and sector feedback HR20211225 (May 2021), contracting to expand access and choice of primary mental health and addiction supports is split into four workstreams. The Ministry directly contracts with NGOs for the delivery of kaupapa Māori, Pacific and youth primary mental health and addiction services, and contracts via DHBs for Integrated Primary Mental Health and Addiction (IPMHA) services.

22. Data reporting for IPMHA services uses a newly developed reporting system based on the national Health Index (NHI) while reporting systems for the NGO services in the other three workstreams is in the early stages and not NHI-based. There is no baseline data for the access and choice services. The IPMHA reporting system has operational since 1 July 2021. It will take time for NGO providers' reporting to mature to a standard where publicly reporting is appropriate.

23. It is **recommended** that initial reporting for access and choice should report data from IPMHA services, expanding to all providers as the NGO dataset is validated and a timeseries is established.

The intervention logic

24. The aim of this indicator is that more people can access primary mental health and addiction services (percent of population with at least one face to face contact). The main areas for action include implementing NHI-based reporting for all providers; ensure access for Māori, Pasifika and youth through actions based on barriers and enablers and informed by data; and workforce recruitment, retention, and productivity.

Participation in bowel screening programme (improving wellbeing through prevention priority)

25. This indicator sits under the priority of improving wellbeing through prevention. The other high-level indicator is ambulatory sensitive hospitalisation (ASH) rates in adults aged 45 - 64. Previous sector feedback was that neither adult ASH nor participation in bowel screening requires services to take a strong focus on wellbeing or prevention. ASH aims to reduce hospital admissions through improved management in primary or

community care while line-of-sight actions to improve participation in bowel screening do not focus on prevention or public health interventions such as healthy eating.

26. Two intervention logics for this developmental indicator were prepared for discussion at the workshop:

    i. Participation in bowel screening programme
    ii. Reducing bowel cancer incidence

27. There is inequity in bowel cancer incidence and trend over time with rates in Māori increasing (both male and female) while for non-Māori incidence rates have been declining.

28. Workshop participants favoured a focus on preventive health, with actions to support whānau to stay well. This includes risk stratification to identify those most likely to benefit; screening and brief intervention for risk factors; self-management support, education, and resources; and co-designed wrap around services including social services.

29. Review of the intervention logics favoured reducing bowel cancer incidence as a high-level indicator, supported by participation in bowel screening as a mandatory contributory measure. A focus on reducing bowel cancer incidence will allow regions considerable scope to undertake prevention activity and many of these activities (smoking, alcohol, obesity, physical activity, and nutrition) overlap with preventive activities for non-communicable diseases. This would complement activity to reduce adult ASH rates.

30. Constructs and actions that support reducing bowel cancer incidence that were endorsed at the workshop were:

    i. Patients and whānau are informed and aware of bowel cancer risks.
    ii. Patients and whānau are aware of benefits and able to access screening and early detection for bowel cancer. Actions and contributory measures to improve participation in the bowel screening programme sit in this dimension.
    iii. Patients and whānau are supported to identify and reduce risk factors for bowel cancer.
    iv. Patients and whānau receive high-quality, equitable care.

31. It is recommended that the high-level indicator is reducing bowel cancer incidence, with participation in the bowel screening programme a mandatory contributory measure.

Financially sustainable health system

32. Ten potential indicators were put up for discussion at the workshop, focusing on three drivers of expenditure and sustainability: workforce, capital, and technology. It was noted that technology expenditure is confounded by an increasing move to using software as a service. Increasing expenditure would be difficult to interpret – it could reflect investment or wastage / duplication. It was therefore agreed to develop high-level indicators on workforce and capital investment.

Workforce

33. Workforce expenditure represents approximately 66 percent of Vote Health and workshop participants supported a workforce indicator as being important from both a

financial and sustainability perspective. This incorporates the quadruple aim for quality improvement[3] adding the fourth pillar of improving the work life of the health care workforce.

34. Two aspects of workforce were discussed:

    i) measures of staff wellbeing and

    ii) FTE growth relative to service demand. A limitation is that these measures only include the health workforce directly employed by the hospital sector (no dataset is available for the primary and community sector).

35. Staff wellbeing is important for a sustainable workforce, particularly during COVID-19. Metrics include sick leave usage, long-term sick leave, annual leave balances over two years, vacancy rates, wellbeing/satisfaction surveys and staff retention (turnover/length of service). Performance on each of these measures has cost implications. However, the group concluded that as high-level indicators, each one of these was either difficult to interpret or had the potential to create the wrong incentives and / or unintended consequences.

36. Drivers of health workforce FTE growth include increasing demand as a result of more acute care and increasing clinical complexity; workforce shortages; the long training pipeline; use of locums; and increasing numbers of staff working part time. Potential indicators include contracted FTE per 100,000 population, FTE against a measure of hospital volume and ethnicity of health workforce as a proportion of resident population.

37. The preferred option was contracted FTE per 100,000 resident population[4], using trend over time to consider the balance between sustainability and cost. FTE growth can be a good thing and contribute to sustainability, for example, through the use of Care Capacity Demand Management (CCDM). Other workforce growth may also be positive by improving satisfaction and reducing burnout. However, increasing workforce to compensate for inefficiencies or shortcomings in technology or capital is less positive. Monitoring growth by occupation will be useful to see whether implementing different models of care (including the increased use of technology), ensuring staff are working at the top of their scope and changing the make-up of the workforce (e.g., employing more peer / whānau or community support workers) are having the desired impact.

38. It is recommended that contracted FTE per 100,000 population is the high-level indicator, with the other measures forming part of the contributory measure suite.

Capital investment

39. Workshop participants agreed the purpose of the indicator would be to measure whether the right investments in capital are being made. This could include age of assets

[3] **The Triple Aim for quality improvement aims to optimise health system performance through improved quality, safety and experience of care, improved health and equity for all populations, and better value**

[4] **Note this currently doesn't include primary health care as there is no reliable data source**

to measure whether are assets being used beyond their life expectancy or are in poor condition, or an indicator of deferred maintenance.

40. Limitations to available data narrowed potential indicators (for example, there is no national data on deferred maintenance or assets in poor condition), while indicators such as the age of assets, are difficult to interpret meaningfully. Age alone does not determine whether an asset is in poor condition.

41. An indicator of expenditure on asset repairs and maintenance as a percent of total net book value of assets (excluding land) is proposed. This would provide insight on how much a district health board is spending on maintenance, both reactively and proactively.

42. It is recommended that expenditure on assets repairs and maintenance as a percent of total net book value of assets is the second high-level indicator. If this is agreed, further work to identify contributory and balancing measures will be undertaken.

Equity

43. The implementation of the HSIs supports the health system meeting its Te Tiriti o Waitangi obligations. All non-financial measures, including the headline measures and contributary measures, will be stratified by ethnicity, which will clearly highlight differences in health outcomes for Māori. Further disaggregation by age and gender will help identify the largest equity gaps. These will help the system to respond to Te Tiriti principles of equity and active protection, sharing information with Te Tiriti partners.

44. The new Māori Health Authority and Iwi Māori Partnership Boards will be involved in agreeing on priorities with Health New Zealand and the locality networks. Locality network alliances will involve Māori providers, iwi and whānau to ensure that local activity, supported by local measures, focusses on areas of importance to Māori.

45. Each indicator will monitor change by ethnicity and achieving equity will be a focus. An intervention will not be considered a success if it worsens or does not improve differences between Māori, non-Māori, and non-Pacific populations.

46. There is a deliberate cross-over between Health System Indicators and the measures in Whakamaua: Māori Health Action Plan 2020-25. While some measures are specific to each set, the two frameworks share key measures. Therefore, efforts to address a number of the indicators are directly supported by actions in Whakamaua.

47. In the medium terms it is expected that the measures in the HSIs will evolve as new information becomes available and the strategic focus of the system evolves. Whakamaua contains an action, from the Health Services and Outcomes Kaupapa Inquiry (Wai 2575), to co-design measures of pae ora (health futures). As these measures are developed and implemented it is expected they will influence future iterations of the HSIs.

Consultation

48. This report has undergone consultation with HQSC and Treasury and been shared with Te Aho o Te Kahu. The proposal on the workforce indicator has been discussed with TAS.

Next steps

49. The HSIs framework will be an important component of the monitoring arrangements for the new system.

50. We are working with the Transition Unit to understand the future structures and entities in the reformed health system that will be responsible for developing and implementing improvement plans. We will issue guidance to the sector on the new accountability framework and will publish a guide on how to use HSIs for quality improvement, in collaboration with HQSC.

Appendix One: Main themes of workshop discussions framed under the key system shifts.

The themes are oriented towards improvement actions for providers across the system – some are specific to a sector, such as primary health care, while other actions are relevant for all.

Te Tiriti principles

- All providers have a role in ensuring principles of Te Tiriti o Waitangi are upheld.
- Iwi Māori Partnership Boards (IMPB) seen as an important mechanism to ensure locality improvement plans include Te Tiriti principles and focus on addressing inequities.
- Whānau trust and engagement is an important aspect of access into services and for some whānau there is inter-generational distrust. Resolving this may include addressing dis-trust created by previous poor experience of health care, poor follow-on care, and lack of collaboration between providers. Solutions include 'ecomapping' across localities of hāuora Māori services and establishing, encouraging, and monitoring e-referral mechanisms. Co-located to deliver services where communities gather and combine multiple agencies, e.g., health, housing, and education. Iwi Māori Partnership Boards could be a mana-enhancing way to improve access.
- People and whānau need choice. Services need to be co-designed with Māori to help ensure they are the first choice for patients and whānau. Ask whānau about the value they place on tamariki/rangitahi and their ora and reflect this in the measures and activities.
- Upholding Te Tiriti needs a workforce that is competent to engage with Māori and higher needs whānau. Providers need to ensure their workforce has the capability to engage with Māori.
- All providers need to understand their data on access to and quality of care for Māori and take action to address inequities. Applying a strengths model, co-design must be authentic.
- Focus on underlying issues and mechanisms of inequity to inform improvement (who did you ask, what did they say, how is the voice reflected?)
- Engagement may require time spent on wider conversations rather than transactions.
- Consider iwi affiliation, mātauranga Māori, non-traditional providers e.g., rongoā

System shift: the health system will reinforce Te Tiriti principles and obligations to address current inequities and provide a stronger voice and influence for Māori, including a new Māori Health Authority and Iwi Māori Partnership Boards.

Integrated primary and community services to support people to stay well in communities

- Take a life-course approach, address social determinants of health, and apply the principles of proportionate universalism to promote population health. The financial benefits and links to a financially sustainable health system of prevention and early intervention was underscored.
- Proposed actions should be evidence-based and include early identification, intervention, and prevention. Activities could improve health literacy and support self-management through behavioural change and increasing self-efficacy, and address key modifiable risk factors (diet, physical activity, alcohol, and smoking). This would require additional investment, for example through expanding the role of primary care nurses.
- Trust is an important aspect of access and engagement into services. Which patient groups are more likely to report not being as involved in decisions as much as they would like?
- Localities could explicitly integrate services by linking providers. Shared care plans across all involved providers are vital.
- Access to community services varies between regions. Integration requires both providers and consumers to have a locality-based understanding of what services are available in a region, who is providing them and how to connect. For example, allowing referral between general practices for speciality services such as iron infusions or long acting reversible contraception. Currently, this practice is limited by capitation clawbacks.
- Limits on what and how services are funded creates complexity for providing integrated services. Examples include access to specific services after-hours, the ability to access group visits for primary mental health or who is funded for insulin starts.
- All regions should support primary health care to provide access to diagnostic services including advanced imaging. Addressing this could reduce some post-code lottery, especially for conditions like lung and bowel cancer where there are high prevalence and late diagnosis for Māori and are important drivers of inequity and mortality.
- Allow patients to self-refer for specific services, for example, contraception, sexual health, or self-management groups.
- Widening access through allowing enrolment to occur with a wider range of providers.
- Outreach and wraparound care need to be protected.
- Integration requires the sector to be aligned. One approach could be to the development of regional plans across all providers with clear shared priorities and regular review and supporting strong links between types of providers.

System shift: people will have more support to help them stay well in their communities through a better range of integrated primary and community services with increased access and protected funding to help them stay well.

Equitable access to emergency or specialist care

- Proportionate universalism could provide a framework for appropriate use of resources, enabling an increased level of resourcing to be applied proportionate need.
- Equitable access to specialist care starts with access to primary care. There needs to be equity at each point in the pathway, using data to inform improvements, for example, equitable primary care enrolment and referral rates (adjusted for need). Are patients actively engaged or are some patients first accessing care via ED?
- Much of the focus was on taking an integrated systems approach, with good data sharing and led by whānau preferences.
- Discussion on primary health care capacity, measures of availability and access including extended hours.

Emergency access:

- This links to the adult ASH indicator and requires effective management of long-term conditions (risk stratification, medication review, recalls and care plans with anticipatory medicine).
- What options are available in the community, e.g., diagnostics, home-based monitoring, hospital in the home, outreach. Are primary options for acute care (POAC) operating as intended?
- What time are patients arriving in ED, is after-hours access a problem? 'See and treat' services offered by ambulance can reduce need for ED care.

Access to specialist care

- Timeliness of care across the patient journey is important.
- How many planned care procedures are completed in primary care or in the community? Increased access to physician to physician consults are more effective than e-advice request.
- Referral process. Are health pathways used? Referral rates by practice, quality of referrals (what percent are returned as incomplete). Do decline letters provide the information that primary care and patients need? Who gets to refer?
- Concept of hospital in-the-home as a way to address indigenous health and rural population (Australian example)
- Prioritisation. Is a formal triage process used? Are procedures prioritised using a nationally approved tool?
- What is the interface and information flows between primary and secondary care like? Transfer of care – who transfers care, is it criteria based, is sufficient information provided for GPs, Māori health providers and the patient? Does it include proactive or preventive care, e.g., checking immunisation status and developing a plan for the whole whānau? Weekend discharges?

- Improving access to secondary services requires workforce issues to be addressed (planning, recruitment, retention, wellbeing, professional development

System shift: high quality emergency or specialist care when it's needed to ensure equitable access through services planned to ensure the best distribution of care and equitable access across all regions.

Digital services provide more care in people's homes

- Telehealth is considered particularly important for rural communities.
- Services should be provided based on patient preference. During the first lockdown most hospital appointments were virtual, after lockdown this reverted to face-to-face, largely due to provider preference (custom and practice). Did patients want this change to be ongoing?
- Patient portal use. Evidence suggests use improves patient-provider relationship, shared decision making and engagement in self-management, but implementation and functionality varies. Some practices only allow limited functionality while others provide a lot more health information including test results, diagnoses, management resources, scheduling, and referral status.
- Making technology and / or funding available for undertaking home-based monitoring for ASH-related conditions like chronic obstructive pulmonary disease or diabetes may improve care and prevent admissions.
- Caution on too much focus on digital and telehealth as high needs communities are less likely to have reliable access to data and technology. The counterview was that some Iwi and those less confident approaching services are increasingly asking for telehealth consultation; and apps that have perceived non-judging humans.
- Point of care access / live chat currently isn't covered in primary care funding model, although potentially could be.

System shift: digital services and technology will provide more care in people's homes and communities building on the virtual care we saw during the COVID-19 response and providing more ways for people to access safe, quality, and convenient services.

Workforce

- The importance of the health workforce was raised at every workshop.
- The lack of planning and co-ordination to ensure that tertiary education providers are supplying the needs of the health system was raised as a long-standing problem in need of being addressed. The over-reliance on overseas trained health care workers is unethical (NZ capitalises on other countries' investment in the health workforce)
- Long wait times for appointments is a key barrier to access for primary health care and mental wellbeing support and is likely in part to be due to workforce shortages.

- Implementing different models of care was viewed as a possible solution. Increasing the training pipeline is important but not sufficient given the long lag time and the volumes required. Ensure practitioners are operating at the top of their scope and broaden the type of roles, for example, NGOs who are trusted in their communities may be able to support better navigation to services who can address social determinants of health. Using the existing health workforce more effectively, e.g.: increased role of pharmacy to provide frontline care. Upskilling non-clinical and associated staff to make best use of clinical time.
- Further discussion is presented in the paper under the financially sustainable health system priority.
- Ensure the workforce reflects the ethnic composition of the population served. What percent of the resident Māori and Pacific population are represented in the health workforce? Strategies to address this include ensuring the advertising and recruitment processes are attractive to Māori and Pacific. This links with Whakamaua: Māori Health Action Plan. Strategies in Health Science programmes are also required to ensure access pathways for Māori and Pacific students are prioritised.
- Importance of consolidating practice-based evidence and horizontal learning
- Importance of retention of the health workforce by addressing working conditions and burnout. Retention can be supported through pay equity across sectors. e.g., ensuring pay parity for nurses in primary care with those employed in hospitals. There is also a need to increase proportional investment in primary and community care services, it is not sustainable to continue asking primary care to do more with minimal investments in teams.
- Need to design and develop the workforce

System shift: Health and care workers will be valued and well-trained ensuring we have enough trained people, resourced to provide better services for our communities.

Data-informed quality improvement

- The underpinning philosophy of the framework is that regions and localities use quantitative and qualitative data to understand population needs and opportunities for improvement using benchmarking. This will require some regions to increase their access to data and capability and capacity to use it.
- The Commission's measures library will be enabler, especially for regions with less existing data capability and capacity. Analyses by age, ethnicity and gender could be provided to regions and localities.
- The lack of national primary care data remains a barrier for national quality improvement initiatives. Current patient management systems do not support whānau approaches to care that include the whole social context

- Integrated data between providers was noted as an enabler for all HSIs, for example, data sharing between Well Child services, general practice and oral health would enable opportunistic care and help identify those who are missing out. This requires actively working with other agencies to share information.

Culturally safe services

- The workforce should be supported to provide locally appropriate, culturally safe care. While training is a necessary component, it may not be sufficient and further development may be needed (for instance reflective practice).
- Using data to identify differences in care by ethnicity, e.g., audit of care provided and self-reflection on own biases.
- Navigator/kaiāwhina roles and broadening partnerships across the NGO sector may improve early engagement and navigation.
- Some of the community engagement and outreach undertaken regarding COVID-19 could be continued although this would require considerably more funding.
- Involve relevant target populations in communication and engagement planning to ensure they understand the key messages.

COVID-19-related disruption

- What needs to happen to manage the effects of COVID-19-related disruption? Has an aligned whole-sector plan been developed with all stakeholders? Are protocols needed to ensure ongoing delivery during COVID-19, e.g., how to deliver childhood vaccinations?
- What approaches from COVID-19 should be continued, for example, community-led outreach, virtual appointments. How is collaboration between different agencies encouraged?
- What opportunities, capacity and capability do we now have as a result of the COVID-19 response that we can now re-purpose/join/extend/duplicate?
- What care has been missed during the last two years and how are we ensuring those gaps are being addressed?