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# RE: Measure sets including balancing measures for Health Targets 5th instalment Imms at 2yrs





First and most importantly wanted to check in that you were OK – so sorry to hear of yet more turbulence for you guys and hope that you are not too badly affected.

I have been through all of these measure sets, and have some general and specific comments.

### General

Most of the measures are really contributory (i.e. measuring the operation of the system to hit the target) rather than balancing for perverse unintended consequences) that's fine but I've suggested some balancing measures below where I think these might help

WRT to contributory measures I was slightly unsure where the milestone target levels and dates come from. Are these a/ based on modelling of the system operation in order to understand the required operation of different parts of the system in order to hit the target; b/ based on maintaining/ improving current position or c/ other. My only concern is if not a/ then how do you know the relationship between the contributory and headline measure well enough to set a target level? I guess in other words do you have to achieve all of these contributory level measures to hit the top one? If not why have the targets at this level?

#### Specific

ESPI 5: Potential balancing measures

- 1 Refused referrals (geographic variation, equity)
- 2 Distribution of time between FSA and decision to treat (would identify if a cohort of patients being "held" in an outpatient loop)
- 3 Median time waiting
- 4 90/5th percentile time waiting
- 5 ratio 90/5th percentile to median time waiting (3-5 derive from the theoretical work on waiting lists from King's Fund/ Audit Commission/David Speigelhalter about 25 years ago still think this is the most convincing articulation of how elective rationing through waiting works.

# ESPI 2: Potential balancing measures

1, 3, 4, 5 as above

#### lmme

I would recommend adding who is missing what i.e. % with all, % missing 1, % missing more, % missing all—logic is that this distinguishes between a child being slightly late for one versus the total anti-vax position—better describes the true nature of the position and progress and actions we need to take. With a register approach this should be possible.

## FCT

The quality and pathways measures to some extent operate as balancing measures here – this make sense (with the milestone and date caveat above)

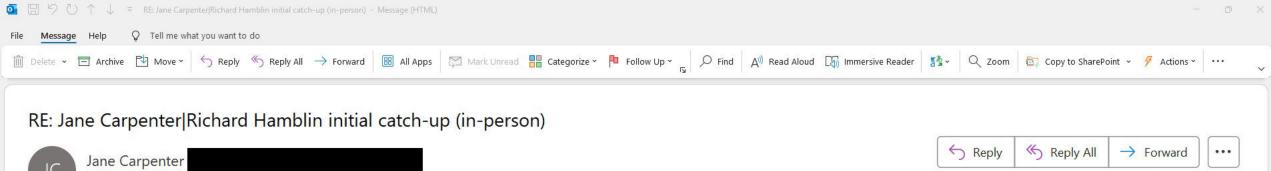
#### ED

These looked really good to me – you might want to consider something around a state of play either end of the acute journey (i.e. primary care and potentially ARC and community care) in order to inform interventions

Really happy to talk through – and on the safety paper

I will share these comments with Duncan Bliss

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Thu 19/06/2025 10:59 am

Kia ora Richard,

(i) You forwarded this message on 19/06/2025 11:40 am.

Nice to catch-up and identify opportunities to work together on Health Targets over the coming year.

My notes from the conversation is below for our records, and I spoke to Jo Williams about the balancing measures and gaming and unintended consequences analysis and I believe she will share that work with you (feel free to give one of us a nudge if you haven't got it get).

- Note looking to establish a programme management approach to health targets, which includes establishing a leadership group to provide oversight of the programme and issues and risks intend for HQSC to part of this, will look to establish in July and first meeting second half of quarter, noting finalisation and timing may be affected by the change process. Jane to share workplan when complete.
- Intend to use the Ministry's quarterly system monitoring report to provide the Minister with reporting on unintended consequences and gaming every 6 months and unwarranted variation every alternative 6 months. As well as any novel HT-related analysis prioritised through the Ministry's issues register.
- Also have weekly, fortnightly and monthly reporting in issues, risks, results and activities.
- Initial thoughts from Richard on things that HQSC can do
  - o Insights reporting and soft intelligence eg concern that CRASH / rapid response teams are increasing which may be related to ED admissions before full work-up
  - o Reach tool eg triage levels in ED. Can identify where quality risk lies
  - o ED-specific questions coming from the patient experience survey for the first time
  - o Could provide quality improvement expertise would need to be formally commissioned from Health NZ as some but not a lot of spare capacity
  - o Have commissioned NZIER to look into the cost of delay to quantify the value of improved access
  - o Could also do some re and post PROM analysis in a pilot site eg in relation to knee replacement
- Agreement that the Leadership Group would be an appropriate mechanism to identify areas for collaboration ongoing while that is being established, Jane to discuss above thoughts internally and stay in touch about any potential opportunities for collaboration.

Ngā mihi, nā

Jane Carpenter (She/Her)

Principal Advisor

Regulation and Monitoring