Aide-Mémoire

Health New Zealand
Te Whatu Ora

Improving ED performance and patient flow

Due to MO:	9 October 2025	**Reference**	HNZ00092032
To:	Hon Simeon Brown, Minister of Health		
From:	Chris Lowry, Executive Regional Director, Central Jason Power, National Director, Planning, Funding & Outcomes		
Copy to:	Hon Casey Costello, Associate Minister of Health		
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Contact for further discussion (if required)

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Purpose

1. This aide memoire provides you with an update on the immediate work to improve ED performance, including advice on options for improving performance and patient flow by expanding and enhancing patient alternatives to hospital including early supported discharge, support for frail people and integration with home and community support services.

Summary

2. Throughout Winter 2025, Health NZ has experienced a sustained rise in ED presentations that has negatively impacted our ability to achieve the Shorter Stays in ED (SSED) health target and deliver the timely care patients expect.

3. To address this impact on the SSED target we are implementing an immediate package of initiatives focused on improving the efficiency of our EDs and inpatient services. This package was approved by the Board in September and focuses primarily on increasing staffing to improve flow through the ED (e.g., additional SMOs to make treatment decisions earlier) and improving discharge processes in inpatient areas to reduce length of stay and create capacity to support flow from ED.

4. But improving SSED performance and patient flow cannot be solved in EDs alone. Instead, we need to pull multiple levers across EDs, hospitals, and primary and community care to make best use of our capacity by reducing ED presentations and readmissions.

5. Many of our existing work programmes – such as the Diagnostics Boost, Interim Inpatient Bed Capacity Programme, and Primary Care Tactical Action Plan – will contribute to this goal.

6. There are also opportunities to better support patients in the community to reduce ED presentations and prevent avoidable readmissions, particularly for older adults and those with long term conditions that increase frailty. There are options to expand and enhance several existing programmes to do this, specifically improved discharge planning to aged residential care, restorative home and community support services, early supported discharge services, and hospital in the home models.

7. Health NZ is working with Health NZ teams, and private community providers such including the HealthCare Group to develop options to integrate ESD, HCSS, ARC and primary care to improve support for people at high risk of an avoidable ED presentation and admission. We will update the Minister in November.

Discussion

8. Since the start of the winter period, Health NZ has experienced a sustained rise in ED presentations above population growth. This rise is impacting ED target performance, but also has flow-on implications for hospitals, with many facing occupancy rates greater than 95%, which in turn impacts performance of the planned care targets.

9. You requested a package of actions for the next three to nine months to improve ED performance, with a focus on improved efficiency in EDs. You also asked for options to

better integrate community-based care into hospital discharge processes.

10. The fundamental goal is to optimise the flow of patients through hospitals by making the most efficient use of our hospital beds, such that people who need a bed have it, and people who do not, have access to alternatives. This requires a combined focus of:

    a) good access to primary and urgent care to avoid hospitalisation

    b) diversion initiatives in both emergency transport and EDs where adequate community triage and community supports can avoid the need to attend hospitals

    c) efficient patient flow through EDs and hospitals including early intervention for people admitted to hospital

    d) supporting people to return home as soon as possible when there are sufficient community based supports available and their need for hospital level care has reduced.

Immediate actions to improve ED efficiency

11. In an ED, there are two streams of patients:

    a) **Non-admitted stream:** where a patient receives treatment in ED and is then discharged home.

    b) **Admitted stream:** where a patient is transferred into an inpatient facility from the ED. This cohort of patients is affected by access block and hospital capacity.

12. We consider focusing on the non-admitted stream to be most impactful over the next three months. Dedicating resources to move patients through this system quickly has the potential to rapidly improve performance and achieve the Year 2 milestone (77%). Specifically, we think we can drive performance through:

    a) Earlier senior assessment and decision making in ED (e.g., increased SMO resource to make definitive treatment decision early).

    b) Focusing on ED patient flow (e.g., employing ED flow managers, senior nursing and allied health practitioners to focus on unblocking delays for patients).

    c) Improving patient discharge management and in particular weekend end patient flow and discharges to create in patient capacity and better prepare hospitals for Monday peaks in attendances.

13. We are taking a phased approach to this work:

    a) Phase 1 (September 2025 – January 2026), which focuses on ED and inpatient capacity actions that can be implemented in the short term.

    b) Phase 2 (January 2026 – March 2026), which focuses on actions relating to access to ARC, primary, and community care that can be implemented in the short term.

    c) Phase 3 (April 2026 – June 2026), which focuses on infrastructure and bed capacity leading into next winter.

14. The Health NZ Board endorsed Phase 1 of this approach on 9 September. Funding for

Phase 1 is estimated at $20 million in 2025/26, to be reprioritised from existing budgets given the high priority of driving improvement in this area. It is noted that these investments will present an additional risk to delivery of the Health NZ 2025/26 budget.

15. Regions are working at pace to implement Phase 1 initiatives. Most are dependent on recruitment and a fast-track sign off process is in place to streamline this. Work also is underway to develop a monitoring framework to assess the impact of these actions, noting that SSED performance traditionally improves in Quarter 2.

16. Alongside this ED-specific work, we expect other ongoing initiatives to support ED performance. Phase 1, focused on non-admitted patients in EDs, sits within the context of other initiatives that are under way and that we expect to support improved ED performance. For example:

    a) The Diagnostics Boost Programme will support faster access to diagnostic services, where 40% of people presenting to ED require radiology and 45% of inpatients.

    b) The Interim Inpatient Bed Capacity Programme, which will deliver four inpatient units at our critically overcrowded hospital and increase hospital capacity to support patients who do need to be admitted to hospital.

    c) Actions within the Primary Care Tactical Action plan to reduce presentations to ED, including the 24/7 online digital service and the roll out of the urgent care and after-hours framework.

We also need to use levers outside of our hospitals to prevent presentations and readmissions to ED

17. We know that using levers within ED and hospital alone is not enough to make a sustained impact on ED performance and improve patient outcomes. Rather, we need to make better use of services that prevent presentations to ED, and avoid readmissions, particularly for older people.

18. When we look at patients who stay in hospital for longer than ten days, people who are transferred to EDs by ambulance but only stay a short time, and those older than 45 years who are admitted but have no significant clinical interventions, we have identified a large cohort of patients who could benefit from community-based care.

19. Additional investment in health services that provide community-based early intervention – with the aim of avoiding hospital and ED admissions – will potentially reduce hospital pressures and cost.

20. Below we outline some of these considerations of the range of options being considered and how they could be expanded to improve ED performance and outcomes for patients.

21. Pursuing any of these will require cost benefit analysis to understand the impact on our hospitals. This includes consideration of working with the funded sector, the private sector and our Health NZ provider models. The analysis includes the impact on the SSED, FSA, Treatment and Faster Cancer Treatment Health Targets by our hospitals.

Early supported discharge (ESD)

22. ESD models facilitate earlier discharge or hospital avoidance by providing rehabilitation, nursing, and home support to patients at home or step-down settings. For example,

ESD teams can provide intensive rehabilitation during a short stay in ARC after a person is discharged from hospital. International evidence shows ESD programs can shorten hospital lengths of stay, reduce readmissions, lower health care costs, and delay or prevent hospitalisation.

23. Health NZ is working with private and Health NZ providers to identify the most effective and affordable option for scaling Early Supported Discharge models across our hospitals to reduce inpatient bed days. Each District has local variation, and we are working through the options and impacts that should be considered.

24. ESD models are being used across New Zealand and, while there is no standard model, two key evidence based ESD services are in place:

    a) START Service in Waikato (Supported Transfer & Accelerated Rehabilitation Team) has been in place since 2010 and evaluated in two randomised control trials which found that the service reduced the initial hospital stay by approximately 6 days per patient. Importantly, START also reduced subsequent hospital use over the 6 months post-discharge, with ESD patients spending 5 fewer days in hospital (for medical cases) and 3 fewer days (for injury cases) compared to control groups, indicating fewer relapses or readmissions. Work has progressed to extend START across Te Manawa Taki. Central is also rolling out START.

    b) CREST Service in Canterbury has been in place since 2011. Like START, interdisciplinary teams and trained support workers provide up to four visits daily for personal care and exercises. These programs report not only shorter hospital length of stay, but also lower 30-day readmission rates and reduced long-term care placement for their elderly clients. Te Waipounamu region are developing plans to implement evidence based Early Supported Discharge models across the region

    c) ACC's Non-Acute Rehabilitation Pathway (NARP) provides dedicated funding based on the proven START and CREST programmes for ACC patients.

25. Adoption of ESD models alone will not be sufficient to lower bed days. For example, despite the use of the START service in Waikato, Health Roundtable data comparing for 2024/25 shows that Waikato's proportion of actual bed days to expected bed days is still one of the highest in the country.

Restorative service model for people using home and community services (HCSS)

26. A national restorative HCSS model of care is being implemented across New Zealand to replace the traditional HCSS. To date, approximately half of all people receiving HCSS services have been transitioned to the restorative model, and all services are planned to use the new model by 2027.

27. The restorative model of care requires HCSS providers to collaborate with NASC, primary care, secondary care, community providers, and ARC to facilitate integration across the health system, identify health decline and increase service delivery to meet patient needs. This model is similar to the MSK pathway model which aims to support peoples' independence by better using the allied health workforce.

28. This model supports ED performance by targeting better and more integrated services for people who are already using our HCSS services. For example, restorative HCSS is aligned with the early supported discharge model used with the START/ CREST

programmes. Providers can increase service delivery to respond to changes in patients' needs when they are discharged from hospital and can support rehabilitation when a patient has finished ESD and requires long-term HCSS.

29. Beyond the initial roll-out, there are options to deliver additional clinical interventions that would support hospital and ED avoidance through the restorative HCSS model. These could include simple primary care activities (e.g., vaccinations and phlebotomy), more frequent interRAI Home Care assessments, simple equipment allocation and low-level district nursing. The goal is to deliver wraparound, early intervention services, and more support in the home, for vulnerable older people when health decline is evident and at the point of hospital discharge. We expect that this proposal would have a positive impact on hospitalisations and ED admission for this cohort. Initial advice on this proposal is due to Minister Costello on 10 October.

Discharge planning and access to ageing well community services

30. Discharge planning involves ensuring that people discharged from ED and inpatient settings have access to the medicines, equipment, and support services they need to transition to care in the community. For older people, this can also include securing a temporary or permanent space in ARC. Improving discharge planning can support the flow of patients out of ED and reduce the likelihood of readmission.

31. When a patient being discharged needs access to ARC, discharge planning includes support to identify a suitable ARC facility (via NASC and hospital social workers). The process of identifying and securing a bed in an ARC facility for people is a major life change and there is potential for decisions to take time because of the complexity of the situation (e.g., family dynamics), and if the person does not have the ability to make decisions for themselves and doesn't have an Enduring Power of Attorney (EPOA) in place.

32. These issues can increase the hospital length of stay beyond when the patients' needs would be better met in an ARC. This is compounded where a patient's preferred location has low ARC capacity, and the patient has to wait until a bed becomes available.

33. Work is under way to reduce the impact of these delays. Budget 25 provided $24 million across four years to reduce barriers and facilitate the timely transition of older people from acute hospital care into ARC in the short term. This funded is managed by regions and is being used to deliver short-term transitional stays in ARC, establishing EPOAs or Protection of Personal and Property Rights orders, training and advice for ARC staff on complex patients prior to discharge to ARC, and hospital-based staff to support transition into ARC. We expect to receive performance reports on the status of these initiatives, covering the first quarter of this funding (Q1 25/26) in the next month.

34. There is also opportunity to better incorporate HCSS services into broader discharge planning, specifically including a person's HCSS provider in the discharge process, which can be critical for successful discharge and avoiding readmission. Trials have illustrated benefit in reduced hospital utilisation.

Hospital in the Home

35. Hospital in the Home and Virtual Care models provide some hospital-level care to people with moderately acute conditions at home, using tools such remote patient monitoring devices and 'virtual wards' staffed by a multi-disciplinary team. It is used as

both a diversion approach from EDs to avoid the need for admission as well as a short stay ESD model. Hospital in the Home in New Zealand was scaled up in the Northern Region during the COVID-19 pandemic. This model strongly aligns with other programmes in this paper (e.g., ESD) that provide enhanced care at home.

36. Previous experience with Hospital in the Home could be built upon to alleviate hospital demand where we face capacity constraints. The models require robust coordination (often utilising telehealth, remote monitoring and rapid-response nursing/medical teams). The cost and capacity savings of Hospital in the Home models have also not yet been robustly evaluated in New Zealand, which would need to occur before we pursue these further.

37. A randomised controlled trial evaluation of a new Hospital in the Home service in Waikato is about to commence (Medicine SMOs and RNs providing care in the person's home). Patients with unplanned ED attendances are provided electronic monitoring equipment (SPARK telemedicine equipment accessed through the SPARK Innovation Fund) and transferred home. Patients who have required hospital admission can be discharged early under this model of care.

Next steps

38. We look forward to discussing these options further with you at our workshop next week.

39. Phase 2 work will continue following our workshop, focusing on actions relating to access to ARC, primary, and community care that can be implemented in the short term. This includes consideration of working with the funded sector, the private sector and our Health NZ provider models. The analysis includes the impact on the SSED, FSA, Treatment and Faster Cancer Treatment Health Targets by our hospitals.

40. You have also requested work to understand the populations that use emergency departments, and the incidence of illness and the impacts of aging and frailty. This work is underway with our population health team and will be available in mid-November.

2 –Regional Deep Dive – Central Region

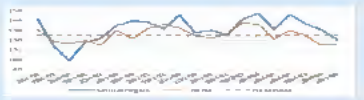
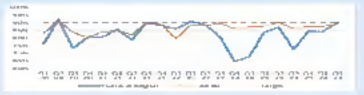
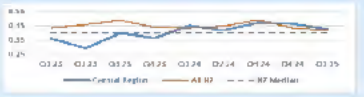
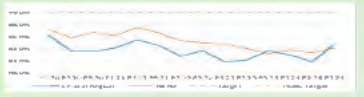
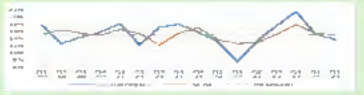
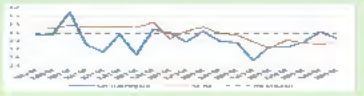
Chris Lowry

- Health Targets
- Quality and Safety
- Radiology Investment
- Major Investment Projects

Central Region Overview

Central Region – Quality Safety Indicaters

Quality and Safety Measures

Focus Area	Measure	Source/Commentary
Self Care Hospital Diagnosis Standardised Mortality Ratio (HDxSMR)	National rate: 115.0 Central Region rate: 120.5 	Central region above national median, and variation exists. Regional team to work with outlier districts on monitoring plans. Health Roundtable Q1 2025
Pressure Injury: % of patients with a documented and current PI assessment	National rate: 83.1% Central Region rate: 85.9% 	Target >=90% Region tracking ahead of national, but below target. HQSC Quality Alerts Q1 2025
Pressure Injury: % at-risk patients with a documented & current individualised care plan	National rate: 89.4% Central Region rate: 90.1% 	Target>= 90% Target met across region Q1 2025. Significant progress. HQSC Quality Alerts Q1 2025
Pressure Injury: Rate of hospital-acquired PI per 100 hospital admissions recorded in NMDS	National rate: 0.42 per 100 hospital admissions Central Region rate: 0.43 per 100 hospital admissions 	Region tracking with national, higher rates in some districts, with monitoring and improvement plans in place. HQSC Quality Alerts Q1 2025
Healthcare Associated Infections (HCA) % compliance with 5 Hand Hygiene moments	National rate: 84.1% Central Region rate: 84.7% 	Target >=90% [HQSC >80%] Region tracking with national, and meets HQSC target HQSC – QSM Period 3 (Jan 2025)
Hospital acquired Staphylococcus Aureus bacteraemia rate per 1000 bed days	National rate: 15.2% Central Region rate: 13.7% 	Data appears out of date. To be followed up with national QPS team. Some variation in rate, but tracking with national rate HQSC – QSM Q4 2023
Post-op Deep Vein Thrombosis/Pulmonary Embolus ratio (Observed vs Expected)	National ratio: 1.1 Central Region ratio: 1.3 	An O/E ratio greater than 1 indicates a higher-than-expected value HQSC Quality Alerts Q1 2025 observed vs expected calculated as a ratio
Inpatient cardiopulmonary (CP) arrests: Rate of in-hospital CP arrests in adult inpatient wards per 1000 admissions	National rate: 0.86 Central Region rate: 0.96 	There was a recent regional 2 quarter increase above national, with some district variation but this is now reducing. Monitoring. HQSC – QSM Q1 2025
Patient & Whānau Centred Care National Patient Experience Survey – inpatients	Were you involved as much as you wanted in making decisions about your treatment & care? National: 80.8% Regional: 81.2% Did the doctors treat you with respect and kindness? National: 91.4% Central: 91.1% Did the nurses treat you with respect and kindness? National: 89.2% Central: 89.8% Did the other members of your health care team treat you with respect and kindness? National: 90.6% Central: 91.9%	Positive responses to these questions have been relatively static across reporting periods, both at a national and regional view. HQSC Quality Alerts: National patient experience inpatient survey (some data reported, not all)

Central Region Overview

- As part of the national radiology initiative the Central Region is implementing a plan to ensure that 65% of people are seen within six months by the end of 2025/26
- Key focus on Hutt MRI and Wellington CT where only 30% of patients are seen on time
- Review of prioritisation of waitlists across the region to better manage patient risk
- Action areas include active outsourcing, improved performance from existing services, targeted recruitment and commissioning new machines (Kenepuru PCCT now operational)
- Focus on getting replacement machines at Mid Central and Wairarapa operational
- Wairarapa MRI Business case being finalised, noting private provider looking to establish a local service in 2026

District	Investment	Commissioning
Hawkes Bay	1 x new CT 1 x replacement SPECT 1 New MRI	FY25/26
MidCentral	1 x replacement CT 1 x new PCCT 1 x replacement SPECT	FY26/27
Wairarapa	1 x replacement CT 1 New MRI	FY26/27
Hutt Valley	1 x replacement CT	FY26/27
Capital and Coast	1 x replacement CT 1 x replacement PCCT 1 x new (Kenepuru) PCCT 1 x replacement SPECT	FY25/26

Central Region Overview

Health Capital Project Update									Reporting Period: Period ending 31 July 2025				
ID	REGION	LOCATION/ CAMPUS	PROJECT NAME	FORECAST CONSTRUCTION COMPLETION	TOTAL FUNDING APPROVED	INDICATIVE TOTAL COST	OVERALL PROGRESS (%)	% SPEND TO DATE	PREVIOUS MONTH OVERALL RAG STATUS	CURRENT MONTH OVERALL RAG STATUS	CURRENT MONTH SCHEDULE STATUS	CURRENT MONTH BUDGET STATUS	CURRENT MONTH SCOPE STATUS
10256	Central	Capital, Coast & Hutt Valley	Wellington Regional Hospital ED Refurbishment (Front of Whare)	May-30	$243.6 m		6%		Green	**Green**	Green	Green	Green
300151	Central	Capital, Coast & Hutt Valley	Acute Mental Health Unit Tranche 2 - Main Works	May-27	$79.3 m		53%		Green	**Green**	Green	Green	Green
10255	Central	Capital, Coast & Hutt Valley	Copper Pipes Tranche 2	Dec-26	$51.8 m		79%		Amber	**Amber**	Amber	Red	Green
10208	Central	Te Matau a Māui Hawke's Bay	Radiology Facilities Redevelopment, Hawke's Bay Hospital	Aug-27	$35.8 m		38%		Green	**Green**	Green	Green	Green
10257	Central	Te Pae Hauora o Ruahine o Tararua MidCentral	Critical Infrastructure Interim Works, Palmerston North Hospital	Dec-26	$29.5 m		63%		Amber	**Amber**	Amber	Green	Green
10266	Central	Te Matau a Māui Hawke's Bay	Temporary In-patient Unit, Hawke's Bay Hospital	Oct-26	$28.3 m		18%		Amber	**Amber**	Red	Green	Green
10260	Central	Capital, Coast & Hutt Valley	Interventional Radiology Unit Upgrade - Phase 3, Wellington Regional Hospital	Dec-26	$20.9 m		38%		Green	**Green**	Amber	Green	Green
10218	Central	Te Matau a Māui Hawke's Bay	Surgical Services Expansion Project (SSEP), Hawke's Bay Hospital	Aug-25	$18.8 m		95%		Amber	**Amber**	Amber	Green	Green
10240	Central	Capital, Coast & Hutt Valley	Renewal of Vertical Transport (Lifts) - Tranche 2	Jul-25	$5.8 m		95%		Green	**Amber**	Amber	Green	Green
30013	Central	Te Matau a Māui Hawke's Bay	Procedure Rooms Upgrade, Hawke's Bay Hospital	Oct-25	$3.0 m		45%		Amber	**Amber**	Amber	Amber	Green
					$516.8 m	**$514.1 m**							