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District health boards:

Learning from 2010–13 Statements of Intent

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1 Introduction

This paper has been written to help district health boards (DHBs) as they prepare their 2011-14 and future Statements of Intent (SOIs). It sets out:

- an overview of the findings of a Consistency Panel, which reviewed the 2010-13 SOIs;
- examples of better practice in:
  - a performance story (Canterbury DHB);
  - main measures and targets (Northland DHB);
  - differentiating impacts from outputs (Hawke's Bay DHB);
  - service descriptions (Hutt Valley DHB);
  - the coverage of the forecast Statement of Service Performance (Bay of Plenty DHB); and
- a discussion about measuring the quality of services.

This paper focuses on only certain aspects of SOIs. The auditor will consider whether the SOI and the annual report, as a whole, give a reasonable picture of actual service delivery at key points through the health system.

We note that DHBs and the Ministry of Health continue to refine the form and content of planning requirements. For example, the Ministry's planning guidelines for 2011/12 require new descriptors for four output classes – Prevention, Early Detection and Management, Intensive Assessment and Treatment, and Rehabilitation and Support.

2 General findings of the Consistency Panel

After reviewing auditors' grades for DHBs' service performance information (and associated systems and controls), the results were:

- Needs improvement – 12 DHBs. The five DHBs discussed in this paper stood out as having made good progress.
- Poor – 8 DHBs.

The Consistency Panel considered nine factors, set out in Table 1, to be particularly important.

Table 1: Key factors assessed when reviewing the 2010-13 SOIs

- There is a coherent performance story, including a clear and logical performance framework
- There are specific, high-level health outcomes for the district's population, main measures and targets (for the period of the SOI)
- There are clearly identifiable impacts, and measures and targets for them*
- There are outcomes/impacts that are successfully differentiated from services (outputs)
- There are services that are identified and clearly and appropriately described
- There is sufficient coverage of significant services demonstrated in the (forecast) Statement of Service Performance (SSP)
- The important dimensions of performance for those significant services are identified
- There is a number of measures of service quality (that is, "pure" measures rather than impact measures, which can indirectly indicate service quality)
- There are baselines, trends, and other information to allow for meaningful comparisons

* Although not required by the Crown Entities Act, the presentation of measures for both outcomes and impacts can enhance the performance information.

The Consistency Panel's general observations were that most DHBs had made notable improvements in their 2010-13 SOIs, compared with the previous year. It found that:

> "For those DHBs the Panel considers are making good progress, a major factor is their apparent understanding of the difference between outputs and impacts/outcomes, the clear separation of these in their intervention logic models, and the avoidance of confusing one with the other either in the framework or in the measures attached to them (i.e. measures of service delivery are attached to outputs and true impact measures are attached to impacts).
>
> Those DHBs that have made only little or some progress are still grappling with basic performance framework issues."

However, the Consistency Panel found that all DHBs still needed to:

- ensure that the DHB's most significant services were properly covered; and
- report more measures of service quality.

3 Examples of better practice

The Consistency Panel identified five DHBs that displayed better practice for an aspect of the performance information.

These examples are not definitive – they show one way, in each case, of presenting the performance information in a better way than some of the other DHBs.

3.1 Performance story – Canterbury DHB

Performance story
The SOI must set out the DHB's planned achievements for the next three years – through identifying desired outcomes or impacts and associated "main" measures of future performance. It must also include a forecast SSP – setting out the performance measures and targets relating to planned services (outputs) for the first year of the SOI. The medium-term and annual information together tell the entity's "performance story". It should be supported by: • key background information on the DHB and its operating environment; and • information on how the DHB will perform its functions and conduct its operations to achieve its specific outcomes or impacts.

The performance story clearly tells the reader what Canterbury DHB is trying to achieve and how it is transforming the way it delivers services to address capacity issues resulting from population growth, an ageing population, fiscal pressures, and the burden of long-term conditions. This information provides a meaningful platform for the forecast SSP.

Canterbury DHB consistently integrates and reinforces key messages through the SOI. Comprehensive information and data support the performance story.

The SOI identifies strategic goals, outcomes (with long-term measures), impacts (with medium-term measures), and outputs (with annual measures).

Strengths of the performance measures, an integral part of the performance story, include:

- having three tiers of measures (for outcomes, impacts, and outputs);
- using comparative information on past performance (trends); and
- the context of demographic change given for some measures.

Canterbury DHB has chosen to present both “long-term” outcome measures and “medium-term” impact measures. It explains that the outcome measures cover 5-10 years and the DHB is “aiming for a measurable improvement over time rather than a fixed target”. It sets headline impact measures for each output class and “3-year targets to measure the impact we are making over time”. Presenting measures for both outcomes and impacts can strengthen the performance story.

The following sections present examples from Canterbury DHB’s SOI to show the strengths of its performance story.

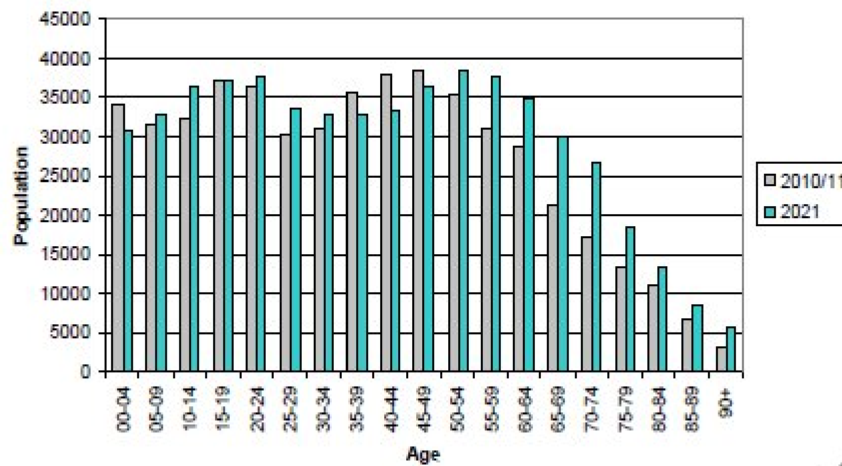
Comprehensive background information

The early sections of the SOI give informative background on matters such as demographics, key health trends, health behaviours and risk factors, demand growth, and fiscal pressures. For example, in the section on demographics, Canterbury DHB comments that:

> “The need for change is starkly apparent in the future demographic projections for the Canterbury population and the resulting impact of these demographic changes if we do nothing to alter our current approach to health service delivery.”

A figure on projected populations by age band (see below) is accompanied by specific statistics and a discussion on the relationship between age and health needs.

FIG 2: PROJECTED POPULATIONS BY AGE BAND
CDHB POPULATIONS 2010/11 VS 2021



The section on demand growth builds on this. For example, it notes that:

> "Assuming that we do nothing to change service delivery models, population forecasts indicate a 22% increase in medical and surgical demand by 2021."

A table of the growth in volume of key Canterbury DHB services over the last four years supports the discussion.

Volume Growth of Key Canterbury DHB Services – at all Canterbury DHB sites [12]

	2005/06	*2006/07*	*2007/08*	*2008/09*	*4 year variance*
New Out Patient Attendances	127,039	131,895	140,119	144,287	*14%*
Follow-up Out Patient Attendances	459,591	455,244	456,308	465,631	*1%*
Total Outpatient Attendances	617,513	628,352	650,364	664,900	*8%*
Day Case Discharges	27,894	32,412	31,267	34,566	*24%*
Inpatient Discharges Elective	8,404	8,600	8,888	9,061	*8%*
Inpatient Discharges Acute	52,903	54,934	55,682	57,447	*9%*
Main Theatre Visits	21,779	23,630	25,044	26,855	*23%*
Total Surgery Time minutes	1,312,710	1,415,050	1,493,721	1,586,712	*21%*
ED Attendances	71,278	71,946	73,691	79,317	*11%*
24 Hour Surgery Attendances	66,770	70,482	71,156	69,011	*3%*
GP Consults	1,116,122	1,200,298	1,227,925	1,229,962	*10%*

Clear strategic direction

This background information gives essential context to Canterbury DHB's strategic direction. The SOI gives a very clear picture of the DHB's strategic direction – it emphasises repeatedly and consistently the theme of re-

orientating the health system to support a more patient-centred approach, thereby addressing the issues facing the DHB.

For example, in a section titled *Unleashing Our Health System*, the SOI discusses removing “artificial barriers to clinically appropriate flow”. In a section setting out the DHB’s vision, it discusses further breaking down traditional boundaries and seeking to shift less complex services from hospital-based settings into primary healthcare and community settings.

Another section, titled *Improving Outcomes for Our Population – What are we trying to Achieve?* incorporates the previously identified strategic goals into a performance framework. Relationships between outputs, impacts, outcomes, and strategic goals are well explained.

The discussion under each strategic goal, and associated outcome measure, reinforces the earlier information. The example below is an extract from the comments under Strategic Goal 2, *People Are Supported Well in their Community*. It confirms the impact of the ageing population on demand for acute services, aged residential care services, and home-based support services:

> “Canterbury is experiencing a growth in demand for acute (emergency or urgent) services that is faster than the growth in our population. There will be over 80,000 presentations at the Christchurch Hospital ED this year, with an equivalent number at Christchurch’s 24 hour general practice service. Population growth and the increasing age of our population are driving much of this increased demand, along with demand for Aged Residential Care (ARC) services. We have the fifth highest age-standardised per-capita utilisation of ARC services and a higher than national average utilisation of home support services.”

Linkages between the medium-term picture and the forecast SSP

The clear outline of Canterbury DHB’s “transformational” approach to services in the medium-term information in the SOI helps the reader to see the linkages through to the forecast SSP. For example, when discussing the medium-term picture in the section on *Unleashing Our Health System,* the beneficial consequences for services are described:

> “The consequence of our transformational focus has been a significant increase in productivity, as evidenced by our reductions in waiting times,

> increases in direct care time on wards, increases in virtual activity (such as First Specialist Assessment), increased access to services across the community (such as spirometry, sleep assessments, and skin lesion removals)…."

A number of the services referred to in the above statement have measures and targets in the forecast SSP.

Tobacco smoking

The specific example below on tobacco smoking shows the linkages between the context and outcome measures in the first part of the SOI with the discussion, impact, and output measures in the forecast SSP. The section on *Health Behaviours and Risk Factors* states that:

> "It is tobacco smoking …that is the single most preventable cause of death. It is a major risk factor for cancer, cardiovascular disease, diabetes and respiratory disease. …Despite the prevalence of smoking amongst our population (18.3%) being lower than the national prevalence (19.9%), over 71,500 people in Canterbury were regular smokers in 2006."[1]

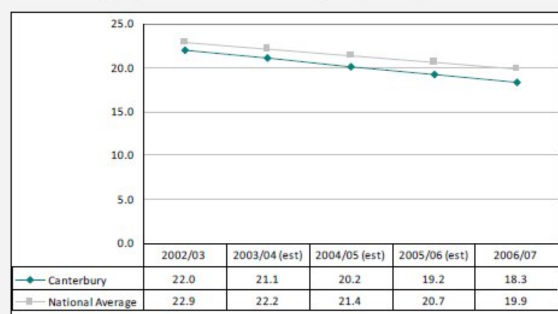
Strategic Goal 1, *People Take Greater Responsibility for Their Health,* has an outcome measure for smoking. The supporting narrative reiterates the significant health impacts from tobacco smoking and the graph shows trends over a five-year period for Canterbury and nationally.

Associated Outcome Measures - We will know we are succeeding when there is:[15]

A reduction in smoking rates for the Canterbury population.

- *Tobacco smoking kills an estimated 5,000 people in New Zealand every year, including deaths due to second-hand smoke exposure. Smoking is also a major contributor to preventable illness and long-term conditions. It is a major cause of lung and a variety of other cancers, as well as chronic obstructive pulmonary disease, heart disease and strokes.*
- *In addition, tobacco and poverty are inextricably linked. In some communities, a sizeable portion of household income is spent on tobacco, resulting in less money being available for necessities such as nutrition, education and health. Supporting our population to say no to tobacco smoking is our foremost opportunity to target improvements in the health of populations with high need and to improve Māori health.*

Long-term Outcome Measure: The proportion of the Canterbury population who smoke (15 years+).



	2002/03	2003/04 (est)	2004/05 (est)	2005/06 (est)	2006/07
Canterbury	22.0	21.1	20.2	19.2	18.3
National Average	22.9	22.2	21.4	20.7	19.9

1 The SOI notes that the data for the outcome measure comes from the national NZ Health Survey collected by the Ministry of Health every three years. The survey was carried out in 2003/04 and 2006/07. Results from the 2009/10 survey are expected to be available in 2010/11.

The forecast SSP has a headline impact measure presented at the start of the Child and Youth Health Services output class. It has output measures in both the Child and Youth Health Services output class and the Adult Health Services output class, under Health Promotion, Protection and Disease Prevention Services.[2]

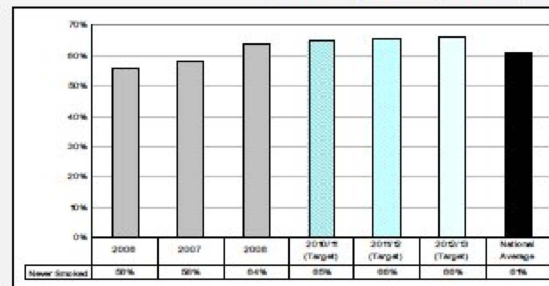
The quality and effectiveness of the services we fund and deliver will be measured using the following impact measures:

A reduction in the proportion of young people who take up tobacco smoking.

- *The highest prevalence of smoking is amongst young people, with approximately one in every four Canterbury teenagers 15-19 currently smoking.*
- *Reducing smoking prevalence is dependant on smoking cessation and on preventing young people from taking up smoking. Over 95% of smokers have started smoking by 18 years of age.*
- *A reduction in the uptake of smoking is a good proxy measure of successful engagement and a change in the social and environmental factors that influence risk behaviour.*

Data sourced from national annual Year 10 ASH Survey.

	Actual 08/09	Target 10/11	Target 11/12	Target 12/13
The proportion of 'never smokers' among Year 10 students.	64%	65%	65.5%	66%



Child and Youth Health Services output class

How will we measure our performance:	Standard 2010/11	Current National Average	Actual 2008/09
The proportion of compliant tobacco retailers identified from controlled purchase operations.	Increase to 90%	-	89%
The proportion of compliant alcohol retailers identified from controlled purchase operations.	Increase to 90%	-	86.9%

Adult Health Services output class

How will we measure our performance:	Standard 2010/11	Current National Average	Actual 2008/09
The proportion of hospitalised smokers provided with help and advice to quit.[32]	Reach 90%	25%	ns
The proportion of smokers identified in primary care and provided with help/advice to quit.	Reach 80%	-	ns
The number of people enrolled in the Aukati Kaipaipa smoking cessation programme.	Increase to 200	-	182

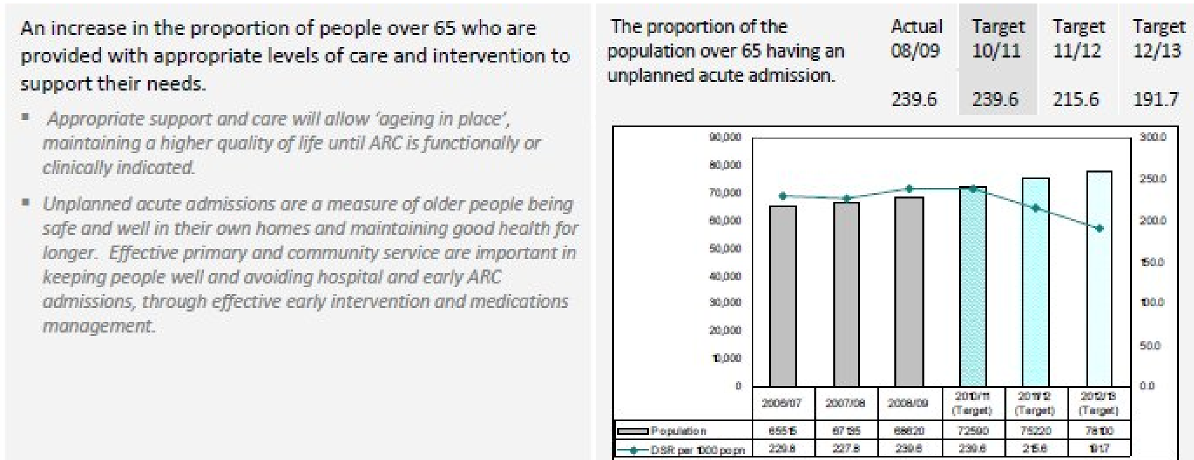
Meaningful performance measures

Canterbury DHB provides trend data for its outcome and impact measures. It provides one year's baseline data for the output measures. This comparative information helps to make the performance targets meaningful.

2 Note that the "output" measures under Child and Youth Health Services are more likely to be low-level impact measures than true output measures. There are, however, also measures relating to smoking under the Adult Health Services output class – these are clearly output measures.

For a few measures, graphs display the historical performance and targets against current and forecast demographic information. This is good practice.

The example below highlights Canterbury DHB's goal of reducing unplanned acute admissions to hospital for those aged over 65, within the context of an ageing population. The example also shows the informative narrative that accompanies the impact measures.



An increase in the proportion of people over 65 who are provided with appropriate levels of care and intervention to support their needs.

- *Appropriate support and care will allow 'ageing in place', maintaining a higher quality of life until ARC is functionally or clinically indicated.*
- *Unplanned acute admissions are a measure of older people being safe and well in their own homes and maintaining good health for longer. Effective primary and community service are important in keeping people well and avoiding hospital and early ARC admissions, through effective early intervention and medications management.*

The proportion of the population over 65 having an unplanned acute admission.	Actual 08/09	Target 10/11	Target 11/12	Target 12/13
	239.6	239.6	215.6	191.7

3.2 Main measures and targets – Northland DHB

Main measures and targets
The SOI should clearly set out the outcomes the DHB seeks to contribute to or influence, **AND**/**<u>OR</u>** the impact the DHB aims to have, and identify associated performance measures. These "main" measures of future performance cover the full three year period of the SOI and they sit above the measures of service performance (output measures – which are part of the forecast SSP). The relationships between these different elements of performance should be clear so that the reader can understand how the DHB believes that the goods and services it is accountable for will ultimately result in improved outcomes.

Northland DHB notes that it has been developing a more rigorous intervention logic to improve its SOI. It says:

> "This is encapsulated in our SOI Framework which neatly captures all the elements of the performance story in one diagram."

The framework (set out in an appendix) is a diagram of the different layers of performance information. It starts with Northland DHB's vision and progresses through high-level outcomes, outcomes, impacts, and outputs. It depicts the relationships between these.

Northland DHB has identified two sets of performance measures in relation to its outcomes and impacts in the framework and a set of output measures.* In the framework it has organised the measures under each impact, which means that the reader can easily identify all measures relating to a particular area (such as cancer). Northland DHB told us that it decided on this structure in preference to organising its measures by output class, because often this would have meant splitting measures for one impact across several output classes (for example, the tobacco impact has measures belonging to prevention, primary care, and hospital services). To help the reader identify output classes, though, the measures have been colour-coded across the impact columns.

High-level outcome measures

At the highest level, Northland DHB has identified four directional measures for its high-level outcomes:

- increased life expectancy for the Northland population;
- decreased mortality rate (age-standardised);
- decreased infant mortality; and
- decreased gaps between (a) Māori and non-Māori, and (b) Northland and New Zealand.

Although these measures may seem self-evident, including them in the performance framework makes them explicit and signals Northland DHB's intent to actively monitor them, report on them, work towards achieving them, and keep them in mind during all its planning.

* As previously noted, the presentation of measures for both outcomes and impacts is not required by the Crown Entities Act.

Providing information on trends for high-level outcomes is useful context for impact measures, which reflect more directly the achievements of the DHB.

Impact measures

Northland DHB identifies four of the Impact Measures as its "main" measures of future performance.[3] Some of the measures are commonly used by DHBs, such as *Proportion of population who smoke* and *Five-year-olds who are caries-free.* Other measures are not – for example, *Improvements in quality of life among patients receiving elective surgery*.[4] These other measures represent Northland DHB's efforts to identify measures that relate directly to the impacts described, some of which may not yet have reporting systems established.

Output measures

The third layer of performance measures relates directly to the services (outputs) which underpin the achievement of impacts/outcomes.

Example of the "story" told by the performance measures

The following extract of impacts, outputs, and associated performance measures for cancer, from Northland DHB's framework, shows how the output and impact measures work together to provide a useful picture of planned service delivery and the impact, or effectiveness, of those services.

With appropriate reporting of measures at these levels, the reader should be able to get a picture of both the DHB's performance in delivering cancer services and its progress towards achieving desired impacts and outcomes. Ultimately, the performance information links through to outcomes (such as *Prevention of illness and disease*, and *Minimal impacts for those with long term conditions*).

Impacts	Cancer For curable cancers, increased likelihood of survival. For incurable cancers, reduced severity of disease symptoms.

3 See section 141(1)(f) Crown Entities Act 2004.
4 It is not clear from the SOI how the DHB will measure this.

Impact Measures Main Measures	For breast cancer, cervical cancer and major cancers: • new cases • survival rates • deaths
Outputs	Screening for breast and cervical cancers. Provision of radiation therapy, chemotherapy.
Outputs Measures Health Targets	Targets for breast cancer screening in eligible populations. Targets for cervical cancer screening in eligible populations. People diagnosed with cancer who receive radiation treatment within 6 weeks (till Q1 2010/11) or 4 weeks (from Q2 2010/11). People diagnosed with cancer who receive chemotherapy within 6 weeks.

The section on the rationale behind the impacts and outputs of the SOI discusses the links between outputs and impacts. This helps the reader to understand the impacts and main measures of performance that Northland DHB is using.

The comments on diabetes, cardiovascular disease, and cancer are set out below, as an example. Screening and early access to treatment are linked to the two impacts of survival rates and reduced severity of symptoms.

Impact	Rationale	Contribution made by Outputs
Diabetes and CVD Cancer	Screening for diabetes and cardiovascular disease (CVD), and waiting times for cancer radiation therapy are two of the six national Health Targets. Together the three conditions account for about three-quarters of deaths and are major	A three-pronged set of strategies is necessary: • preventing LTCs (see action above under obesity, tobacco, breastfeeding) • screening to pick up conditions as early as possible • effectively managing conditions once they have

	causes of illness and restricted functioning. They are "long term conditions" (LTCs), so called because once diagnosed, people usually have them for the rest of their lives. Prevalence of LTCs increases with age, so action now is imperative in the face of an ageing population.	developed through an active partnership between clinicians and patients. For cancer, some of the biggest gains are to be made in ensuring early access to treatment (both radiation therapy and chemotherapy) to improve the chances of recovery. NDHB has a Project Manager for LTCs, who is working with providers across the health sector to improve the detection and management of conditions.

3.3 Differentiating impacts from outputs – Hawke's Bay DHB

Differentiating between impacts and outputs

DHBs are required to specify outcomes **and/or** impacts in the SOI. Impacts are the contribution made to an outcome by a specified set of outputs and/or actions. Outputs are the goods or services produced by the DHB.

In previous years, DHBs have often reported low-level impacts, and their associated performance measures, as if they were outputs (and their associated measures). This may be at least partly because:

- some low-level impacts measures could also (quite validly) be regarded as proxy measures of output quality (for example, in the health promotion area)
- the difference between impacts and outputs has been unclear.

Also, some measures could be appropriately reported at either level in the performance framework (such as immunisation coverage measures).

Nevertheless, being as clear and consistent as possible in differentiating impacts from outputs is important. The impacts should demonstrate whether the DHB's services are effective and the DHB is providing the "right" services, within the broader context of its outcomes.

Hawke's Bay DHB identifies five impacts (in addition to outcomes). Its impact measures and targets are similar to other DHBs. However, what sets it apart from some DHBs is the attention it pays to the impacts, with specific narrative discussion on each of them, and the clear differentiation of impacts from outcomes and outputs.

The impacts are clearly set as the bridge between health services and desired outcomes, as shown by the following two statements.

> "The following section [3.5 *Outcomes and Priorities*] outlines HBDHB's intervention logic, which links our output plans to the highest level outcomes and demonstrates how we will meet national, regional and district priorities and measure progress toward achievement of the outcomes sought."

> "In order to contribute to these outcomes [four outcomes it has outlined] HBDHB considers the impacts of our outputs on the population that we serve."

Context from the Population Health Continuum of Care

The SOI presents an overview of the continuum of care for population health and the most relevant set of services at each point on the continuum to give

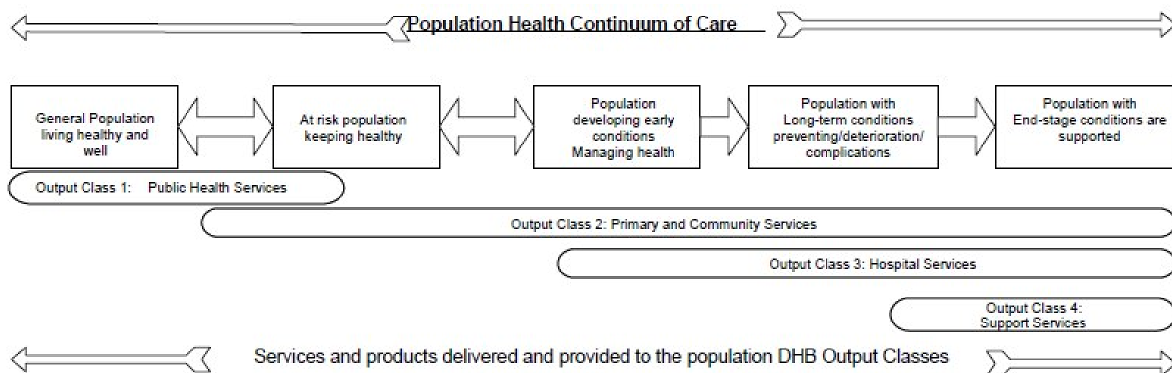


Figure 3 - Population Health Continuum of Care

useful context to the ensuing discussion on impacts.

Information provided on each impact

Hawke's Bay DHB highlights the impacts by presenting them as headings:

> "Impact 1: People are better protected from harm, more informed to support healthier lifestyles and maintenance of wellness, and inequalities are reduced"

It clearly and succinctly explains what this means and the rationale for the impact. There is a clear focus on the effectiveness of services.

Hawke's Bay DHB then identifies which output class(es) and services primarily contribute to the impact. For example:

> "Hawke's Bay DHB programmes in this area include health promotion and education services, statutory and regulatory services, population based screening programmes, immunisation services, well-child services and school health services."

Finally, there is a sub-section under each impact titled *How will we demonstrate success?* This section identifies and expands on the choice of performance measures (which are identified in a table after the discussion of impacts).

The example below, on fruit and vegetable consumption, relates to one of two measures Hawke's Bay DHB plans to use to monitor nutrition:

> "Fruit and vegetables are highly nutritious and have been shown to protect against a range of chronic diseases, including heart disease, stroke and many cancers. In New Zealand it is recommended that adults eat at least three servings of vegetables and 2 servings of fruit daily and we will use the New Zealand Health Survey to show if our efforts at promoting this is effective in our district."

The sentences confirm the rationale for the choice of measure (protection against chronic diseases), the role of the DHB (promotion – linking back to earlier discussion under the impact), the focus on understanding the impact of the DHB's health promotion services (the effectiveness of its efforts), and the links back to outcomes (protection against chronic diseases will result in better health for the community).

3.4 Service descriptions – Hutt Valley DHB

Service descriptions
DHBs are responsible for a great many services. Output classes are used to group similar services. DHBs should clearly disclose and describe the services in each output class.

Hutt Valley DHB identifies its services through:

- an initial overview in the first part of the SOI; and
- descriptions given at three different points in the SOI.

Overview

Hutt Valley DHB gives an initial overview of services in a background section in the SOI. The section on its scope of work outlines the range of services under its provider role and the range of services under its funder role. For example, one of the services listed under the funder role is:

> "Aged residential, respite and home based support services – contracted providers include 17 aged residential care facilities, which provide a mix of rest home, hospital, dementia, psycho geriatric, day support and respite care services, and three home based supports service providers."

This information provides an immediate view of the volume and range of these services.

Forecast SSP

In the section on the output classes and Statement of Forecast Service Performance, the SOI introduces each output class with an overview of what the output class includes, key areas of focus, and more detail on the services that comprise the output class – the latter is highlighted in a table with a background colour.

The examples below are from the output class *Public Health Services (Prevention Services from 2011/12)*.

Scope of the output class

We found the way the scope was described in the following paragraph useful:

> "Public Health services are publicly funded services that protect and promote health in the whole population or identifiable subpopulations. They prevent disease and enhance the health status of the population as distinct from the curative and support services. Public Health services include health promotion to ensure that illness is prevented and unequal outcomes are reduced; statutorily mandated health protection services to protect the public from

toxic environmental risk and communicable diseases; and individual health protection services such as immunisation and screening services."

Table detailing the underlying services

Hutt Valley public health services environment

Public health services are delivered through a range of providers within the Hutt Valley district. Regional Public Health is the main provider of public health services for the greater Wellington region. Other providers include the DHB, Primary Healthcare Organisations, private and non-governmental organisations e.g. Maori providers, Sports Trust and local and regional government.

Regional Public Health
Regional Public Health (RPH) is a regional service within Hutt Valley DHB, serving the populations of Capital and Coast, Hutt Valley and Wairarapa DHBs. Regional Public Health is responsible for delivering most of the outputs that make up the Public Health Services Output Class Statement of Forecast Service Performance (Table 7 refers):

- Health Promotion Services and Education Services; working with our communities, local government and government agencies to ensure that the settings in which people live, work, play and learn can support healthy choices.
- Statutory and Regulatory Services; address such issues as sanitation, water quality, food safety and control of the spread of infectious diseases.
- Immunisation, Well Child, and School Health Services; preventing disease and improving health for families/whanau, children and young people through individual service delivery such as immunisation, new entrant health screening, ear van service and vision and hearing tests in school and preschool settings. Many of these services are also provided by Primary Care and Well Child Providers.

Population Based Screening
The Ministry of Health contracts the Hutt Valley DHB to provide the regional breast cancer screening service (BreastScreen Central) and national cervical screening coordination services (National Cervical Screening Programme). (Table 7 refers)

- BreastScreen Central provides breast cancer screening for women aged 45 to 69 years from fixed and mobile sites throughout the Hutt Valley DHB, Wairarapa DHB and Capital & Coast DHB regions.
- Hutt Valley DHB provides one of the 12 regional National Cervical Screening Programme coordination services throughout New Zealand.

Extract from formal forecast SSP

The formal tables of forecast service performance then set out services, performance measures, and targets. The services reflect those already identified in the earlier tables and another brief description of them is given.

"**Health Promotion Services and Education Services include**: programmes such as: Healthy Communities, Health Promoting Schools, Nutrition and Physical Activity, Sexual Health, Early Child Health, Injury Prevention, Mental Health awareness, Prevention of Alcohol and other Drug related harm, Tobacco Control, and provided by Regional Public Health, Primary Care, and NGOs." [Relevant measures and targets are then set out.]

3.5 Coverage of the forecast SSP – Bay of Plenty DHB

Coverage of the forecast SSP
The coverage of the forecast SSP is the biggest challenge for DHBs. Output classes are the mechanism for grouping outputs of a similar nature. The SOI needs to provide a picture of planned service delivery that is detailed enough to be meaningful to the reader but does not swamp the reader with information. There are two aspects to coverage: the services and the performance measures. • The forecast SSP should give proper coverage of the significant services for which the DHB is responsible. • The performance measures should give a rounded and proportionate view of performance. They should include measures relating to the quality of services, as well as quantity, timeliness, and any other types of measure where relevant. The reader should be able to see the level of service provided and how well it is being provided. Given the volume and complexity of services for which DHBs are accountable, it may be helpful for them to comment specifically on why their selection of services and performance measures appropriately represents their significant services.

Bay of Plenty DHB clearly identifies the services (outputs) under each output class. (As noted earlier, there are new descriptors for the four output classes from 2011/12 – Prevention, Early Detection and Management, Intensive Assessment and Treatment, and Rehabilitation and Support.)

The nature of the outputs identified within each output class suggests that the forecast SSP has a reasonable level of coverage. Table 2 below summarises the outputs.

Table 2: Outputs in each output class

Public Health Services Output Class
Health Promotion and Education Services
Environmental Health and Compliance
Population Based Screening Programmes

Support Services Output Class
Needs Assessment and Support Coordination Services
Palliative Care Services
Home Based Support Services

Immunisation Services
Primary and Community Services Output Class
Primary Health Care Services (GP services)
Oral Health Services
Primary and Community Care Programmes
Pharmacist Services
Community Referred Test/Diagnostic Services
Community Mental Health Services
Hospital Services Output Class
Mental Health Services
Elective Services
Acute Services
Maternity Services
Assessment Treatment and Rehabilitation Services
Allied Health Services

Aged Residential Care Bed Services
Respite Care Services
Day Services
Allied Health Services
Community Mental Health Services
Addiction Services
District Nursing Services

Bay of Plenty DHB specifies considerably more performance measures than other DHBs. The number of measures needed to give a concise and useful summary of the DHB's performance without "over reporting" is a moot point. Apart from the question of "how many is too many", examples of performance measures that are not commonly reported by other DHBs in their SOIs are:

- under *Public Health Services:* measures on schools participating in a Rheumatic Fever prevention throat swabbing programme, and on environmental health inspections of Early Childhood Centres;
- under *Primary and Community Services:* measures on the number of pre-school and primary school children provided with oral health services, the number overdue for their scheduled examination, and completion times for laboratory tests;

- under *Hospital Services*: measures on available bed days for mental health patients, and inpatient detox waiting times; and

- under *Support Services:* measures on patient satisfaction with Needs Assessment and Support Coordination Services, and the number of respite care days.

Some of these measures are clearly very specific to Bay of Plenty DHB (such as the rheumatic fever measure). The relevance of this measure is clear from the information on the district's health profile – "Maori children and youth in the Bay of Plenty also have substantially worse indicators for …acute rheumatic fever (and chronic rheumatic heart disease) that are amongst the highest in the world".

The volume of measures is, of course, just one aspect of a quality forecast SSP – a DHB should aim to portray performance with as concise a set of measures as it can to give a meaningful picture. Importantly, the measures need to be relevant, both to the DHB's significant services and to readers, and cover different dimensions of performance – such as timeliness, quantity, and quality.

Bay of Plenty DHB's forecast SSP shows a lot of potential because the performance measures are supported by a comprehensive outcomes framework (Appendix One to the SOI). The framework presents the following hierarchy of information against each of Bay of Plenty DHB's nine strategic goals:

- long-term population health outcomes, and related performance measures;

- specific services it provides;

- the impacts its services are designed to have, and related performance measures;

- the specific outputs it purchases; and

- a description of how it will know when the outputs are delivered successfully.

It colour-codes the outputs to describe the relevant output class to which they relate. Although the DHB recognises that its framework is still evolving, it is comprehensive and helps the reader to see the "fit" of the outputs and performance measures in the forecast SSP with the bigger picture. It allows the reader to better assess the coverage of the forecast SSP.

4 A discussion about quality

Quality performance measures
Quality is an important dimension of output performance. SOIs should include measures of the quality or standard expected of outputs, where practicable.

4.1 Output quality measures used by DHBs

The Consistency Panel observed that the SOIs contain few measures of the quality of outputs (services), particularly direct measures of quality (as opposed, for instance, to impact measures that may indirectly indicate service quality).

More than half of the DHBs appear to have five or fewer performance measures relating directly to service quality.[5]

Table 3 sets out some commonly used measures of quality, and Table 4 sets out some measures that are not commonly used but clearly relate to the quality aspect of performance.

Table 3: Commonly used measures of quality

Acute re-admissions to hospital (18 DHBs)
30 day mortality rate (10 DHBs) • Rate of mortality within 30 days of discharge from hospital (the parameters of this measure may vary between DHBs)

[5] We recorded in a spreadsheet performance measures from the SOIs that may relate to the quality dimension of output performance. The spreadsheet is subjective and inconsistent – for example, if a DHB identified a measure as a measure of the quality dimension of performance but it was not clear to us how the measure was demonstrating quality, we included it in the spreadsheet for that DHB. We did not, however, consistently include it in the spreadsheet for any other DHBs using that measure. Bearing that in mind, the spreadsheet is available for discussion purposes from the auditor.

Elective Services Performance Indicators Compliance (9 DHBs) (DHBs could consider explicitly identifying which ESPIs measure the quality of service provided)

Patient/consumer complaints (6 DHBs)

- Complaints – older people
  - aged residential care services
  - high level of satisfaction with NASC services, measured by increase in positive feedback/decrease in complaints
  - respite care services
  - day services
- Complaints – respite care services
- Support services (NASC) – number of complaints
- Complaints – hospital services
  - number of complaints per patient contact
  - complaints closed within 20 working days
  - Health and Disability Commission complaints that result in a finding of breach of the Code
- Resolution of complaints

Patient/consumer satisfaction (6 DHBs)

- Satisfaction with hospital services
- Percentage of women rating their post natal length of stay as "just right"
- Satisfaction with DHB facilities
- Whanau/family satisfaction with palliative care services

Table 4: Other measures of quality

Hospital services:

- Reduction in central-line-associated bacteraemia
- Surgical site infections
- Hospital-acquired blood stream infections per 1000 bed days
- Proportion of patients with hospital-acquired pressure injuries
- Decubitus ulcers
- Planned day-surgery cases that stay one or more nights
- Patient falls
- Audit score for hospital responsiveness to family violence, child, and partner abuse

• Compliance with World Health Organisation hand-hygiene guidelines • Improved Health of the Nation Outcome Scales (HoNOS) scores for people discharged from mental health inpatient services
Support services: • Percentage of patients in the palliative service who die in the place of their choosing

4.2 Explicit identification and explanation of measures of a service's quality

It is not always clear which dimension of performance a measure is intended to show. About six of the DHBs do explicitly identify the relevant dimension of performance in at least some cases. However, even in these cases it is not necessarily clear **how** the measure shows a particular dimension of performance.

Giving supporting explanations about the intention and scope of the performance measures, where they are not self-evident, would add value to the performance information.

For example, Taranaki DHB has a measure on the percentage of total acute admissions that were treated as day-stay cases. It comments that a decrease in the percentage of these could indicate fewer inappropriate admissions. This comment clarifies the rationale for the measure and target.

4.3 Certification and accreditation

Lakes DHB uses a number of measures relating to certification and accreditation (for example, that medical practitioners hold relevant and current practising certificates and that hospitals are accredited).

It is for the sector to decide on the appropriateness of including these measures in the forecast SSP. You may wish to consider it, so we bring this to your attention.

4.4 Other insights into the quality of service delivery

We acknowledge that DHBs present a number of valuable measures in their SOIs, which form part of the picture of the overall quality of the health services. These include:

- measures that directly measure other dimensions of performance but can also be regarded as sub-components of the overall quality of a service – for example, the timeliness of cancer treatment (timeliness dimension) and the number of mental health clients with current relapse prevention plans (quantity dimension) are also likely to be integral to the overall quality of the service;
- coverage/uptake measures – for example, screening rates to detect breast cancer can be an indicator of the quality of health promotion services; and
- impact measures – for example, the rate of ambulatory sensitive admissions to hospital can be an indicator of the quality of health promotion services and primary health sector care.

These measures are often useful proxy measures of the quality of output delivery. Nonetheless, the Crown Entities Act requires output measures in (forecast) SSPs. Therefore, it is important that, where practicable, DHBs report using relevant and reliable measures of service quality (as distinct from impact measures or service quantity, timeliness, or uptake measures).

4.5 Conclusion

In conclusion, it is important that there be a discussion at sector level, and that DHBs and auditors discuss output quality performance measures. The conversations could include:

- What measures do DHBs see as measuring service quality? Are they direct measures of service quality? What do DHBs consider themselves accountable for?
- What is the relationship with internal performance management of the quality of services?
- What measures are other DHBs using that could be relevant to them?

- Would there be merit in the forecast SSP explicitly labelling those measures that relate to the quality dimension of performance as "measures of quality"?
- Within the context of key risks, new initiatives/services, and business-as-usual, do the planned measures give a reasonable and proportionate picture of output quality for significant services?
- How, or should, basic certification and accreditation requirements of medical practitioners and facilities be reflected in the forecast SSP?
- What, if any, supporting context is needed to ensure that the reasons for using particular measures is understood by the reader?

5 Link to exemplar DHBs

Canterbury DHB:
http://www.cdhb.govt.nz/communications/documents/pdf/SOI/SOI2010-13.pdf

Northland DHB:
http://www.northlanddhb.org.nz/images/stories/documents/ndhb%20soi%202010-2012%20final.pdf

Hawkes Bay DHB:
http://www.healthcarehb.co.nz/files_download.asp?id=100005812&x=1

Hutt Valley DHB:
http://www.huttvalleydhb.org.nz/Article.aspx?ID=1838

Bay of Plenty DHB:
http://www.bopdhb.govt.nz/PDFs/BOPDHB-SOI-2010-13.pdf