Briefing

Health New Zealand
Te Whatu Ora

Secondary Briefing: Information systems and data availability

Due to MO:	18 February 2025	**Reference**	**HNZ00078406**
To:	Hon Simeon Brown, Minister of Health		
From:	Stuart Bloomfield, Interim Director Data and Analytics		
Copy to:	n/a		
Security level:	In Confidence	**Priority**	Routine

Action sought	**Action required by**
Decision on whether you wish to meet with Officials to discuss contents further.	28 February 2025

Contact for further discussion (if required)			
Name	**Position**	**Phone**	**1st contact**
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Attachments	
Appendix 1:	Rapid vs National Collections
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Purpose

1. This briefing provides you with an overview of Health NZ's data sources (Information Systems) and their appropriate use; data available to you, the public and our internal leaders; data quality assurance processes and issues with data availability and our plans to address them.

Summary

2. Health NZ uses established national data collections and has developed new datasets for operational purposes. This paper describes each and their appropriate use for performance and activity reporting. Great progress has been made to connect and give visibility to data across the country.

3. Many key metrics are currently reported publicly to you and to healthcare services within Health NZ.

4. Gaps in our system intelligence remain, due to paper-based systems in hospitals, technical debt in ageing systems and infrastructure, the siloed nature of data, and the siloed structure of the workforce. This paper describes planned actions to remediate these gaps.

Recommendations

Health New Zealand | Te Whatu Ora recommends that you:

a) **Agree** to meet with Officials to discuss contents of this Briefing more in-depth, if you deem necessary.	**Yes/No**

Hon Simeon Brown, Minister of Health

Date:

Stuart Bloomfield
Interim Director Data and Analytics
Health New Zealand | Te Whatu Ora

Date:

Background

5. Prior to Health NZ forming, public healthcare services were mainly delivered from 20 different district health boards (DHBs). Those DHBs all had data environments, some very complex and mature, some provided by a third-party vendor. The maturity of district data warehouses was largely related to the maturity of their clinical digital landscape.

6. That data and digital landscape has posed several challenges. We rely on multiple legacy systems and manual processes for data collection. Clinicians in most hospitals still write progress notes, vital signs and medications on paper. These outdated systems make it difficult to obtain timely and reliable information.

7. One of the primary issues is the fragmentation of data across 42 different data warehouses, which complicates the integration and analysis of data. This fragmentation affects the overall quality and usability of the information.

Data Sources and their appropriate use

8. Broadly, there are four main sources of data for performance and activity reporting:

a. National Collections

National Collections are long-established, nationally standardised datasets of key information created primarily for public accountability, planning and funding purposes. They are the gold standard historical record that Ministry of Health use for monitoring purposes. They undergo rigorous processes to ensure internal consistency, logic checks (e.g., does event start date come before end date) and adherence to standardization. The greater need for data curation at both the district and national ends of the data pipeline means that data is usually not complete across all districts until approximately two months after the event end date.

With the exception of waitlists, collections are retrospective; that is, data is only submitted after the event (ED visit, hospitalisation, clinic visit, first cancer treatment) is completed. The data lag for the National Minimum Dataset for Inpatient Events is even longer because it requires clinical coding from mainly paper patient records of diagnoses, comorbidities and procedures.

National Collections are the main source of verified and quality assured data for the performance of Health NZ as a single national entity. The data flows for each collection from district data environments. In the case of the Mental Health National Collection PRIMHD, data also is submitted from over 200 NGOs.

b. Rapid National Data Automation Programme Datasets (Rapid)

The Rapid datasets were developed after the establishment of Health NZ to fill an important data gap – for operational management and early system signals of performance. These datasets were developed very quickly at a low cost and are now being used to drive operational insights. Information is published internally on Health Targets, daily for one target (Shorter Stays in ED) and weekly for all targets. It is not used for public reporting because it is not highly standardised, is subject to change and does not undergo rigorous data quality assurance. If Rapid data is ever released publicly it needs to be caveated to explain these limitations and risks.

Rapid datasets are submitted daily from all districts and amalgamated nationally. These datasets (which can be used to track performance against three health targets) are used by local, regional and national leadership to make day-to-day management decisions.

Rapid 'top slices' data from the richer data environments of the Districts. That is, the dataset is a critical subset of what is available locally. These datasets accept local standards; that is, do not insist on adherence to national standards. Because of this important distinction from National Collections, data is up-to-date sooner in Rapid collections. Data quality is maintained through wide distribution and use.

In some cases, Rapid data provides operational intelligence that is not available within the local data warehouses and/or analysis capacity and capability. The datasets established under this programme are waitlists, ED presentations, inpatient stays, operating theatre events, and nursing ward resourcing.

c. Various sources

There are other data sources which collate data nationally but are not considered National Collections such as finance, workforce, Mental Health 'Access and Choice' contacts (used for one of the Mental Health Targets), Aged Residential Care and pharmacy subsidies. These datasets are used to report through our accountability documents and to answer requests under the Official Information Act 1982.

d. District data warehouses

At least 42 separate data environments are maintained by Health NZ staff which contain data from patient administration systems, clinical applications, finance and workforce systems. Data quality processes vary across those data environments. The main data assurance process is usage of data for operational delivery of services.

9. Multiple Information Systems feed information into these district data/local platforms. From those platforms, data is submitted to National Collections and Rapid datasets.

10. At least 20 hospitals have key clinical information recorded on paper records (e.g. vital signs, medication prescribing and clinical notes). In addition, all records of outsourced activity are received on paper/pdf. This data requires transcribing and human reading to submit to national collections.

Data Availability

11. Key metrics are published at four levels:

    a) **Publicly reported** through Quarterly Performance Report, Annual Report and public-facing apps.

    b) **Reported to you** weekly and monthly using a combination of National Collections and operational national datasets.

    c) **Produced internally using nationally collated datasets,** a combination of National Collections and operational data.

    d) **Produced locally** using District data warehouses.

Publicly reported performance and activity measures

12. Health Targets and other key metrics are publicly reported through Quarterly Performance Report, Annual Report and published tables using National Collections and the Aotearoa Immunisation Register (see Appendix 2). Reporting includes national results and breakdowns by region, district and ethnicity.

13. Health Target Implementation Plans for all five health targets are published online (https://www.tewhatuora.govt.nz/publications/health-targets-implementation-plan), which set out the actions we are undertaking through to June 2027 to meet interim target milestones (as per the Government Policy Statement on Health).

14. Coinciding with quarter two 2024/25 publication, we intend to report against the five health targets via an interactive online dashboard, with supporting communications and media materials, in alignment with existing quarterly report timelines.

15. Reporting on measures in our quarterly and annual reports includes accompanying narrative to explain results, including actions under way to improve performance.

16. In addition to the health targets, there are 22 measures reported quarterly in the above-mentioned publications and 30+ websites with data available on performance and activity (see Appendix 2).

Reporting to the Minister

17. A new weekly Health Targets report has been established to meet your requirements. The regional reporting pack and A3 dashboard provides information on performance against health targets, related outputs and improvement plans (see appendix 3 and 6).

Internal (Health NZ) national reporting

18. Balanced scorecards are produced monthly at a national and regional level, to ensure internal oversight and management of core performance (including health targets), activity, financials, and workforce (see Appendix 4). The scorecards are produced within three weeks of month end and therefore necessarily use nationally collated *operational* datasets where available.

19. Health target up-to-date reporting is also available weekly and daily through the ED Daily metrics dashboard and the weekly Health Target League Table (Appendices 5, 6)

20. Daily updated, interactive dashboards with drill-through to event level, are available to service providers and analysts across the country. These dashboards use Rapid data, National Collections data or a combination of both.

Local/ district reporting

21. Regions also produce weekly, daily and monthly detailed reports to support operations, produced from their district data warehouses. This data is richer and closer to real-time than the nationally collated datasets, and therefore can report in greater detail, e.g. the doctor responsible for placing patient on a waitlist.

22. The downside to using district data is that local rules are often applied to calculation of measures and are not transparent to regional and national leaders.

Data quality assurance processes

23. We have made substantial progress in implementing the recommendations from the Data Review that occurred in mid-2023[1], which includes undertaking business process reviews of the end-to-end steps to collect, amalgamate, transform and report on data.

24. Several steps are involved in the production of our quarterly reports to ensure data (including for health targets) is final and robust (see Appendix 7). Data quality is assured through District sign-off of key metrics against locally trusted data sources and other relevant assurance processes if data is not derived from Districts (e.g. NPHS Immunisation coverage rates).

25. Data quality of National Collections is maintained through rigorous data checks against national standards, in addition to district sign-off for key metrics.

26. There are not specific data quality sign-off processes against the national operational datasets (Rapid). Data quality assurance is derived from widespread daily and weekly visibility of the data with drill down to event level.

27. Cross referencing between National Collections and Rapid has improved quality in both data sources (e.g. matching patients removed from the waitlist in the Rapid dataset but not removed from the National Collections waitlist are being used to update the National Collection). Conversely the National Collection has been used to refine the reporting of Rapid to only include relevant specialties.

28. Results in our weekly and monthly reports align but are not identical to quarterly results. That is because operational datasets are used for more up-to-date reporting and are less complete and curated than final published results.

29. Executive Leadership Team has a standing agenda item that focuses weekly on operational performance. Its purpose is to maintain oversight of operational performance and ensure execution of improvement actions. This ensures there is clinical and executive leadership for delivery.

30. We note separate briefings are being provided to Minister Doocey on the five mental health targets including data flows and data quality improvement initiatives.

Data availability issues

31. Multiple legacy systems and processes exist to feed information into National Collections which are not integrated and will take time (and resource) to shift onto a common platform. Data is currently maintained across 42 different platforms, which creates siloes of disconnected information. Access to data is especially difficult for primary and community datasets, such as from GP patient management systems, school oral health, and the Primary Mental Health Access and Choice programme.

[1] https://www.tewhatuora.govt.nz/assets/About-us/News-and-updates/Clinical-Data-Review-Report.pdf

32. We are reliant on highly manual processes, with most hospitals having key clinical information recorded on paper records (e.g. vital signs, medication prescribing and clinical notes). In addition, all records of outsourced activity are received on paper.

33. Clinical coding is completed from these physical paper records. Modernisation of clinical coding involving AI or a mobile workforce is not possible with reliance on paper records.

34. Investment in digital systems to record clinical information is essential to modernise these data pipelines at data collection end.

35. The majority of the data and analytics workforce are structured under the Data and Analytics function within Planning, Funding and Outcomes directorate. A number of analyst and data management roles exist within other functions, some as single analysts within a department providing bespoke analytics and using siloed data. This fragmentation of the analyst workforce reduces our ability to standardise and connect data for greater insights.

Planned Remediation

36. A programme (the National Data Platform) is under way to address the common platform issues. The National Data Platform is creating a 'centre of gravity' for healthcare datasets from all sectors and domains; Hospital and Specialist Services (National Collections and Rapid), GP contacts, community dispensing of medications, laboratory and radiology (hospital and community), aged residential and home-based care, medical oncology services and medicines and radiation oncology. More datasets will be added subject to ongoing funding.

37. To address the low digital maturity of hospitals, a paper is under way that proposes roll-out of a low-cost, proven clinical system which provides digital progress notes, vital signs and integrates with medication, laboratory, radiology and other clinical systems.

38. To address the fragmentation of the analyst workforce, the Data and Analytics function has released a proposal to absorb analysts from Finance, People and Communications, Mental Health and Procurement and Supply Chain. This will enable better productivity analysis of human resource, finance and health activity data.

Appendix 1: Rapid vs National Collections

Key differences between dataset groups:

	National Collections	Rapid
Purpose	Primarily public accountability, planning and funding.	Operational management and early system signals of performance
Use	Reporting to the public and Ministry of Health	Internal reporting
Veracity	All fields nationally standardised, high level of curation. *However*, if data does not meet standard, record is rejected – if district does not keep up-to-date with corrections, data collection is incomplete	Local standardisation is accepted, therefore fewer records are rejected. Downside of local standards, not national standards is analysis across some fields is difficult, e.g. reason for removal from waitlists (600+ reasons)
Key differences	Long latency Highly nationally standardised Submitted when event **ends**	Up-to-date Low standardisation Submitted when event **starts**
Caveats with use	Data is not complete nationwide until approximately months from end of event.	For operational use and subject to change No robust validation process – other than usage Data pipeline failures are frequent
Health Target reporting	**PUBLIC REPORTING** Robust validation processes by central National Collections Validation process for metrics at district level	**INTERNAL REPORTING** Considered early indication of official result from National Collections

Appendix 2: Available Public Reporting of Performance and Activity

Group	Measure	HT
Public Health	**Percentage of children fully immunised at 24 months of age**	◎
	Percentage of children fully immunised at 8 months of age	
	Bowel screening rates of adults aged 60–74 years (two-yearly screening interval)	
	Cervical (HPV) screening rates of eligible women aged 25–69 years (five-yearly screening interval)	
	Percentage of women aged 45-69 years who have a breast cancer screen in last 2 yrs	
	Percentage of children enrolled with a general practice (or a kaupapa Māori provider)	
	Percentage of people enrolled with a general practice (or a kaupapa Māori provider delivering general practice care)	
	Percentage of people who received health care from a GP or nurse when they wanted it in the last 12	
	Aambulatory sensitive hospitalisations per 100,000 population ages 45-64 years	
	Ambulatory sensitive hospitalisations per 100,000 population for ages 0-4 years	
Hospital & specialist services	**Percentage of patients to be admitted, discharged or transferred from an ED within 6 hours**	◎
	Percentage of patients to receive cancer management within 31 days of the decision to treat	◎
	Percentage of patients wait less than 4 months for a first specialist assessment	◎
	Percentage of patients wait less than four months for elective treatment	◎
	Number and proportion of inpatient events with a pressure injury diagnosis.	
	Number of inpatient discharges where a fall occurred while in hospital.	
	Inpatients - the percentage of patients who reported they were involved as much as they wanted to be	
	Percentage of missed first specialist assessment appointments	
	Proportion of medical appointments completed through digital channels	

Group	Measure	HT
Mental Health and Addiction Services	Number of people who accessed primary mental health and addiction services through the Integrated Primary Mental Health and Addiction Services	
	Train 500 mental health and addiction professionals each year	◎
	Percentage of mental health and addiction-related emergency department presentations admitted, discharged or transferred within 6 hours	◎
	Percentage of people accessing primary mental health and addiction services through the Access and Choice programme are seen within one week	◎
	Percentage of people accessing specialist mental health and addiction services are seen within three weeks	◎
	25% of mental health and addiction investment is allocated towards prevention and early intervention	◎
	Percentage of rangatahi seen within 3 wks of mental health and addiction referral	
	Percentage of Hauora Māori partners that are meeting their contracted outcome targets	
	Hauora Māori partners that have moved to integrated or outcomes contracts	
	Percentage of IMPBs that participate in setting strategic priorities	
Workforce	Health NZ workforce turnover rate	
	Representation of Māori and Pacific in the Health NZ workforce through increasing diversity of new hires (rolling 12 month average)	
Digital	Number of people accessing My Health Record	

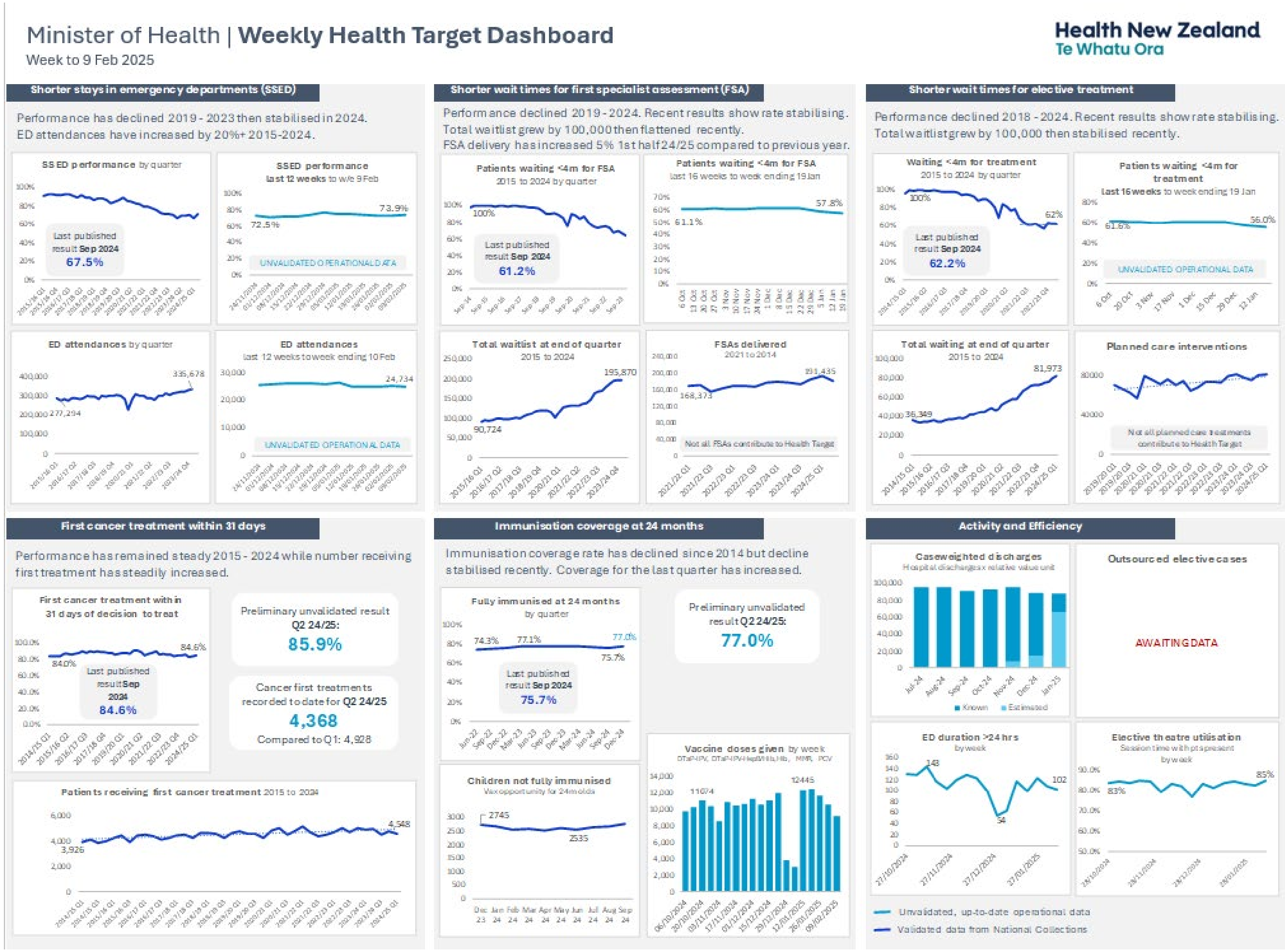
◎ Health Target

Appendix 2 continued: Available Public Reporting of Performance and Activity

Analytics product	Most recent website link
BreastScreen Aotearoa interactive coverage data tool	https://tewhatuora.shinyapps.io/nsu-bsa-coverage/
Cancer Care Data Explorer	https://minhealthnz.shinyapps.io/cancer-care-data-explorer/
Cancer Web Tool	https://tewhatuora.shinyapps.io/cancer-web-tool/
Commissioned Bed Numbers Per Hospital	https://www.health.govt.nz/your-health/certified-providers/public-hospital
Diagnostics Indicator Web Tool	https://tewhatuora.shinyapps.io/diagnostics_indicator/
Hand Hygiene New Zealand dashboard	https://reports.hqsc.govt.nz/hhnz-compliance-dashboard/
Healthcare-associated infection (HAI) point prevalence survey data	https://www.hqsc.govt.nz/our-work/infection-prevention-and-control/our-work/point-prevalence-survey/
Healthcare-associated Staphylococcus aureus bacteraemia (HA-SAB) dashboard	https://reports.hqsc.govt.nz/hasab-surveillance-dashboard/
Immunisation Coverage	https://www.tewhatuora.govt.nz/for-the-health-sector/vaccine-information/immunisation-coverage/
InterRAI Assessments – Including Aged Residential Care	https://www.interrai.co.nz/data-research-and-reporting/data-visualisation-2
Maternity Web Tool	https://tewhatuora.shinyapps.io/report-on-maternity-web-tool/
Mental Health and Addiction: Service Use Web Tool	https://tewhatuora.shinyapps.io/mental-health-and-addiction-web-tool/
National Bowel Screening Programme interactive participation data tool	https://tewhatuora.shinyapps.io/nphs-nbsp/
National Cervical Screening Programme interactive coverage data tool	https://tewhatuora.shinyapps.io/nsu-ncsp-coverage/
Quality & Safety Marker (QSM) reporting	https://www.hqsc.govt.nz/our-data/quality-and-safety-markers/
Respiratory Illness Dashboard	https://www.esr.cri.nz/digital-library/respiratory-illness-dashboard/

Analytics product	Most recent website link
SSI Cardiac Dashboard	https://public.tableau.com/app/profile/hqi2803/viz/SSIcardiacdashboard/SSIIPcardiacsurgery?
SSI Orthopaedic Dashboard	https://public.tableau.com/app/profile/hqi2803/viz/SSIorthopaedicdashboard/SSIIPorthopaedicsurgery
Standardised Intervention Rates (SIR) web tool	https://tewhatuora.shinyapps.io/std_intervention_rates/
Suicide Data Web Tool	https://tewhatuora.shinyapps.io/suicide-web-tool/
Surgical site infection orthopaedic variable life-adjusted display chart	https://reports.hqsc.govt.nz/ssi-ortho-tool/
Waiting List: Elective Services Patient Flow Indicators Web Tool	https://tewhatuora.shinyapps.io/ESPI_app/
Well Child/ Tamariki Ora Quality Indicator Report	https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.tewhatuora.govt.nz%2Fassets%2FFor-health-professionals%2FClinical-guidance%2FSpecific-life-stage%2FChild-health%2FQIF-Mar_2024.xlsx&wdOrigin=BROWSELINK
Virtual Diabetes Register Web Tool	https://tewhatuora.shinyapps.io/virtual-diabetes-register-web-tool/
Fetal and Infant Deaths Web Tool	https://tewhatuora.shinyapps.io/fetal-and-infant-deaths-web-tool/
Hospital events web tool	https://www.tewhatuora.govt.nz/for-health-professionals/data-and-statistics/hospital-event/privately-funded-hospital-discharges-series
National Influenza Vaccine Data	https://www.tewhatuora.govt.nz/for-health-professionals/data-and-statistics/immunisation/national-influenza-vaccine-data
Mortality Data Web Tool	https://tewhatuora.shinyapps.io/mortality-web-tool/
Older people's health data and statistics	https://www.tewhatuora.govt.nz/for-health-professionals/data-and-statistics/older-peoples-health
Oral health - Age 5 and Year 8 data	https://www.tewhatuora.govt.nz/for-health-professionals/data-and-statistics/oral-health/age-5-and-year-8-data
Primary Care indicators	https://www.tewhatuora.govt.nz/for-health-professionals/data-and-statistics/primary-care/primary-health-organisation-performance

Appendix 3: Minister's Weekly Health Targets Dashboard



Appendix 4: Balanced Scorecards

ELT BALANCED SCORECARD

For month NOV 2024

Health New Zealand
Te Whatu Ora

SERVICE PERFORMANCE AND ACTIVITY

			Y1 MILESTONE	MONTH	MTH TREND	TARGET	MĀORI	PACIFIC
HEALTH TARGETS	**ED stays <6 hrs (SSED[R])†**		74%	70.9%		95%	75.3%	69.8%
	First Specialist Assessment < 4 mths (ESPI2[R])		62%	59.6%		95%	59.6%	60.7%
	Planned treatment < 4 mths (ESPI5[R])		63%	58.4%		95%	56.8%	51.0%
	Cancer treatment <31 days (OCT)‡		86%	85.0%		90%	84.0%	92.9%
	Immunisation coverage at 24 mths		84%	75.1%		95%	61.2%	67.4%
SCREENING	Breast screening coverage rate (**OCT**)			69.5%		70%	62.8%	68.4%
	Cervical (HPV) screening coverage rate (**OCT**)			72.2%		80%	63.7%	69.9%
	Bowel screening participation rate (**MAY**)			57.1%		60%	49.8%	38.6%
PRIMARY & COMMUNITY	GP encounters (qualifying for capitation)	as at 16-Jan		1,811,983			266,191	117,515
	Dispensed pharmaceuticals *			8,193,891			1,169,793	548,600
DELIVERY AGAINST	ED presentations[R]			122,246			27,795	10,659
	Caseweighted discharges: Acute/acute arranged	as at 06-Jan		68,784		66,377	(HNZ purchased only)	
	Caseweighted discharges: Elective			21,110		19,273	(HNZ purchased only)	
				MTH ACTUAL	MTH PLAN		YTD AGAINST TARGET	
	Planned care procedures against target			10,334	14,234		61,953	73,773

Green = target met; amber = <2% of target; red = >2% off track

Health Target colour formatting relates to performance against Y1 Milestone

QUALITY AND SAFETY

		MONTH	TREND	MĀORI	PACIFIC
ACCESS	PHO enrolments (as at **01-DEC**)	5,069,835		783,547	372,747
	Newborn enrolments	95.0%		91.5%	93.2%
	Aged residential care subsidised residents (**OCT**)	27,513		1,915	746
SAFE	Healthcare assoc. infection rate (per 10,000) (**OCT**)	106.9		89.1	104.4
	Pressure injury rate (per 10,000) (**OCT**)	5.3		4.6	3.4
PATIENT & WHANAU CENTRED	Pts who could get care from GP when needed (**AUG**)	76.3%		72.1%	74.9%
	Pts treated with respect in hospitals by Drs (**AUG**)	91.9%		88.8%	96.1%
	Missed appointments (%)	7.1%		15.0%	16.3%
EFFECTIVE	Children prescribed preventers	8,821		2,646	690
	Door to cath lab <3 days (**OCT**)	67.5%			
	Average length of stay in days (med/surg)	2.25		2.18	2.58
	Acute readmission rate	Not available			

** claims to be processed and finalised*

† Data are indicative due to current known issues with SSED Rapid data for Auckland district from 30-Oct onwards. This does not affect other Regions.

‡ Data are indicative due to known data issues with data pipeline for FCT. Data are incomplete for 6 Districts for Oct at time of reporting.

FINANCE

	MONTH - NOV 2024 ($M)			YEAR TO DATE ($M)			FULL YR
	MTD	MTD BUDGET	MTD VARIANCE	YTD	YTD BUDGET	YTD VARIANCE	FULL YR BUDGET
TOTAL REVENUE	2,360	2,358	2	11,779	11,790	(11)	28,297
EXPENDITURE							
Internal personnel	1,005	1,038	33	5,190	5,210	20	12,466
Outsourced personnel	34	23	(11)	206	117	(90)	270
Other operating costs	423	424	2	2,152	2,133	(20)	5,007
Primary and Community Services	878	941	63	4,303	4,259	(44)	10,234
Interest, depn and capital charge	114	116	2	579	580	0	1,421
TOTAL EXPENDITURE	2,453	2,542	89	12,431	12,298	(133)	29,397
NET RESULT	(93)	(184)	91	(652)	(508)	(144)	(1,100)

	ACTUAL	BUDGET	VARIANCE	YTD ACTUAL	YTD BUDGET*	VARIANCE
MENTAL HEALTH RINGFENCE ($k) (**SEP Qtr**)	Not available			6,496	6,525	30

All finance numbers are indicative, and were produced on 17-Jan by Finance Directorate
**MH Ringfence budget figure is draft, pending HNZ allocation decision*

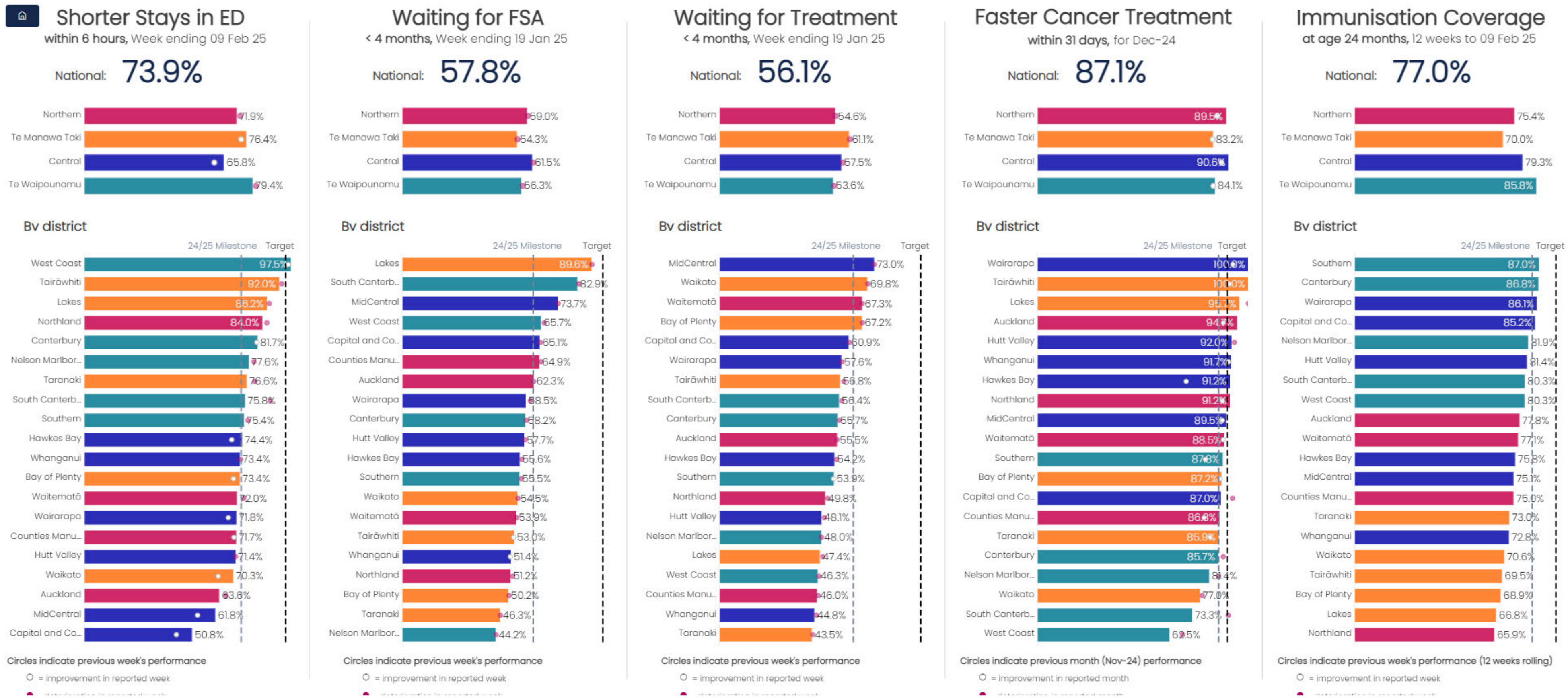
WORKFORCE AND PRODUCTIVITY

WORKFORCE	QTR	YTD	SAME TIME LST YR
Accrued FTE (**MAY**)**	86,813	87,036	
Contracted FTE (**SEP QTR**)	79,674		
Total Sick leave hrs (**SEP QTR**)	2,171,978		
Avg Annual leave balance hrs (per contract FTE) (**SEP QTR**)	200		
Turnover rate (**SEP QTR**)***	1.96%		
Vacancy rate (**SEP QTR**)	6.95%		
Total for Districts (excl Canterbury, West Coast and Tairawhiti)			
Physical assaults on staff (**NOV**)	664		448
Verbal abuse of staff (**NOV**)	761		611

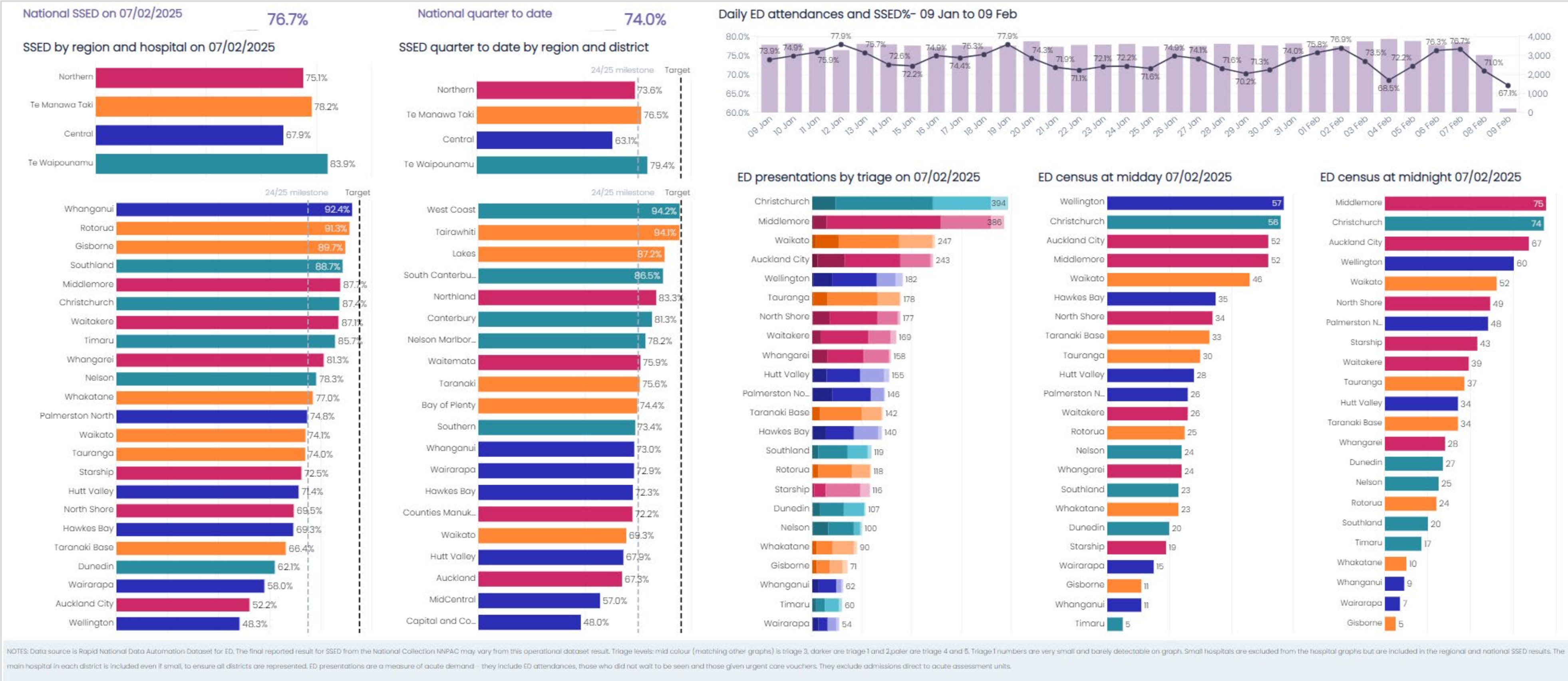
PRODUCTIVITY		NZWAUs	NZWAU/FTE	CWD/FTE
Weighted Activity Units (NZWAU)	as at 06-Jan	122,693	1.53	1.10

All HWIP data as at 30-Sep-2024. Data do not include Health NZ National Office or the former Shared Service Agency employees
***FTE comparator still held at May FTE for Nov reporting due to shift to Contracted FTE in progress*
****Voluntary turnover is calculated by adding up the number of employees who left voluntarily in the quarter and dividing that by*

Appendix 5: Health Target League Table – published internally and to the Minister



Appendix 6: ED Daily Metrics – published internally



Appendix 7: Timeline for publishing Quarterly Performance Reports 24/25

Timeframe	*Q2	Q3	Q4	Step
Quarter end (QE)	31 Dec	31 March	30 June	Quarter ends
9 weeks after QE	27 Feb	29 May	28 August	Draft report submitted to OPC and ELT, and to the Ministry of Health and Treasury and Mins office
10 weeks after QE	4 March	3 June	2 Sept	OPC and ELT meetings Receive draft companion monitoring report from the Ministry of Health Submit to the Commissioner
10 weeks after QE	6 March	5 June	4 Sept	Commissioner meeting
11 weeks after QE	13 March	12 June	11 Sept	Results and publication materials submitted to Minister, along with Ministry of Health monitoring report and Quarter 1 health targets results
12 weeks after QE	w/c 17 March	w/c 16 June	w/c 15 Sept	Report published

*Currently working through data feed issues from Auckland district into national collections which may impact these timeframes. We are preparing an Aide Memoire to you on our proposed resolution.