Aide-Mémoire

Health New Zealand
Te Whatu Ora

Wellington ED performance challenges and response

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To:	Hon Simeon Brown, Minister of Health		
From:	Mat Parr, Acting Deputy Chief Executive – Central		
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Contact for further discussion (if required)

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Attachments

Appendix 1:	2021/22 Independent review findings
Appendix 2:	90-day delivery plan for Acute Flow (mid-February to mid-May 2025)

Purpose

1. This Aide-Mémoire provides you with additional information on Capital and Coast district Shorter Stays in Emergency Departments (SSED) performance and improvement work underway by Health New Zealand | Te Whatu Ora (Health NZ).

Background

2. Wellington Regional Hospital is the Central Region's main emergency and trauma service, and provides secondary and tertiary medical, surgical, intensive care, neonatal intensive care and emergency services. Capital and Coast SSED data is collected for Wellington Regional Hospital Emergency Department (Wellington ED).

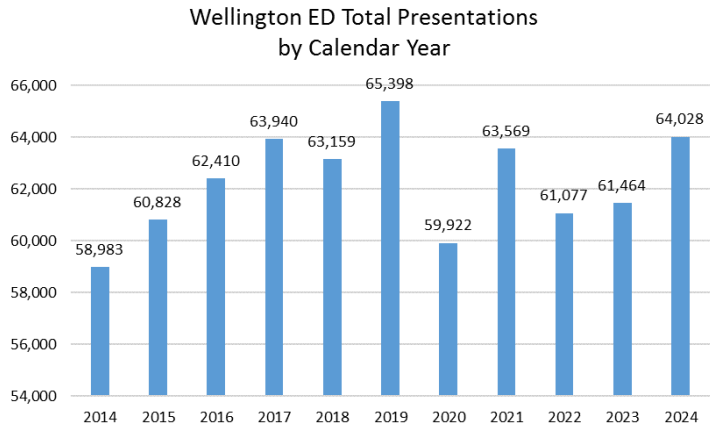
3. Investment into the Wellington ED refurbishment was invited into Budget 2025. A Cabinet paper was presented to you in February [HNZ00071220 refers], which has since been lodged for the 25 March Cabinet Expenditure and Regulatory Review Committee (EXP) meeting, in advance of presentation to Cabinet on 31 March. This investment is proposed to uplift capacity by 126 points-of-care by 2030.

4. As part of your review of the Cabinet paper, you requested additional information on the Wellington ED performance story and work underway beyond infrastructure remediation and replacement to improve performance. This Aide-Mémoire responds to that request.

Historical performance

5. Wellington ED experienced sustained growth in the total number of presentations between 2014 and 2019. Analysis of acute demand growth was undertaken at the time and no clear driver for this growth was identified. In 2020, presentations were affected by COVID-19, followed by a rebound in 2021. Whilst presentations momentarily fell in 2022, the upwards trend seen before COVID-19, and evident in EDs across the country, is continuing.

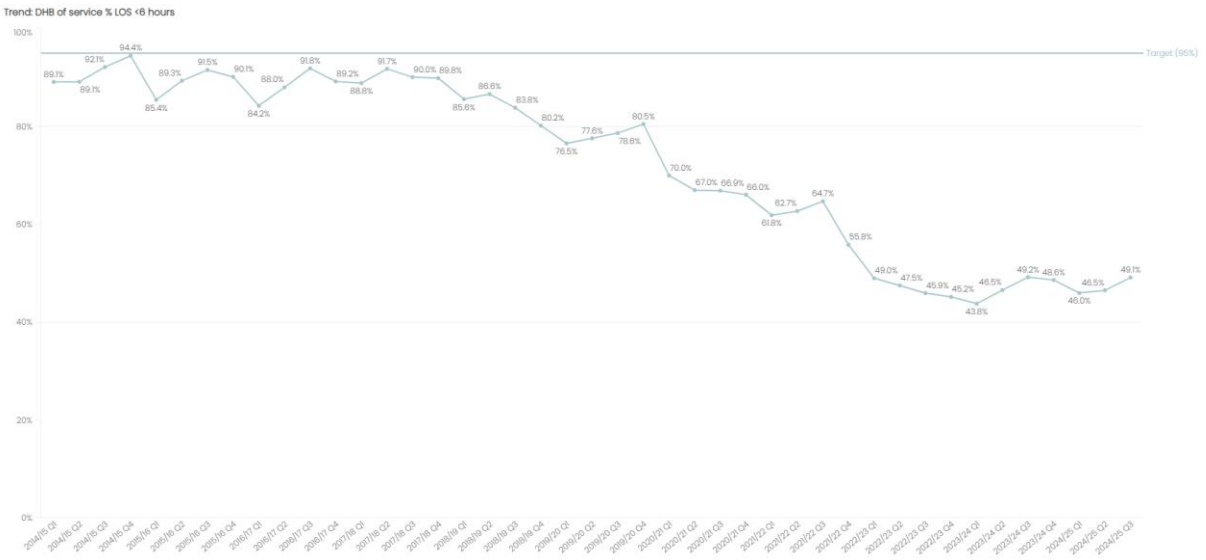
Figure 1: Wellington ED total presentations by calendar year



6. SSED performance held up well until 2019. As detailed in **Figure 2** below, a sustained fall occurred and resulted in performance remaining below 50% since the 2022/23 financial year. Some improvements are shown in recent data, and significant work is now

underway to ensure this improvement trend is sustained.

Figure 2: Wellington ED SSED performance



2021/22 Independent review

7. As demonstrated in the gradual decline in SSED performance, 2019 was the tipping point where hospital capacity (and indirectly ED capacity) reached a critical threshold. Experts independent of Capital and Coast were brought in over 2021/22 to determine the issues that needed to be resolved to improve ED performance in the short term. Key findings are outlined in **Appendix 1**.

8. Recommendations were acted on prior to Health NZ's most recent assessment of Wellington ED challenges as part of the focus on meeting the SSED Health Target. The initial actions in response to the independent review recommendations largely did not result in sustained performance improvements.

Factors for declining performance

9. With the establishment of Health NZ and recent focus on SSED, work has been undertaken to understand the continued drivers behind poor performance and opportunities for improvement. The four main drivers are:

    a. **Higher hospital adult bed occupancy rates and longer adult length of stays:** driving a factor of other issues, including bed block from ED (inability to admit patients to wards), a significant increase in overall length of stays, including long stays (> 24 hours) in ED, and higher workloads for ED and ward staff.

    b. **Increased frailty and complexity:** post-COVID-19, increased frailty and complexity of patients presenting has been a common theme in hospitals nationwide. This leads to increased ED length-of-stay (EDLOS) and inpatient length of stay (IPLOS) as patients stay longer, being treated for more complex illnesses and co-morbidities often associated with age. Longer-staying patients, without additional beds being available, leads to bed blocking and longer wait times for admission.

    c. **System flow issues:** access to suitable Aged Residential Care (ARC) beds in the

community has not kept pace with demand, especially for psychogeriatric and dementia care beds. This prevents discharge of some patients in a timely manner. Flow to primary and community care services is less of a concern, noting the increase in higher-triage patients who must be cared for in a hospital setting.

d. **Capacity issues:** Wellington ED has a design problem compared with other tertiary EDs with a challenging and fragmented layout. It cannot cope when operating above its design capacity, which is most of the time. You have been provided with additional information on these challenges as part of the Detailed Business Case for the Wellington ED refurbishment [HNZ00071220 refers].

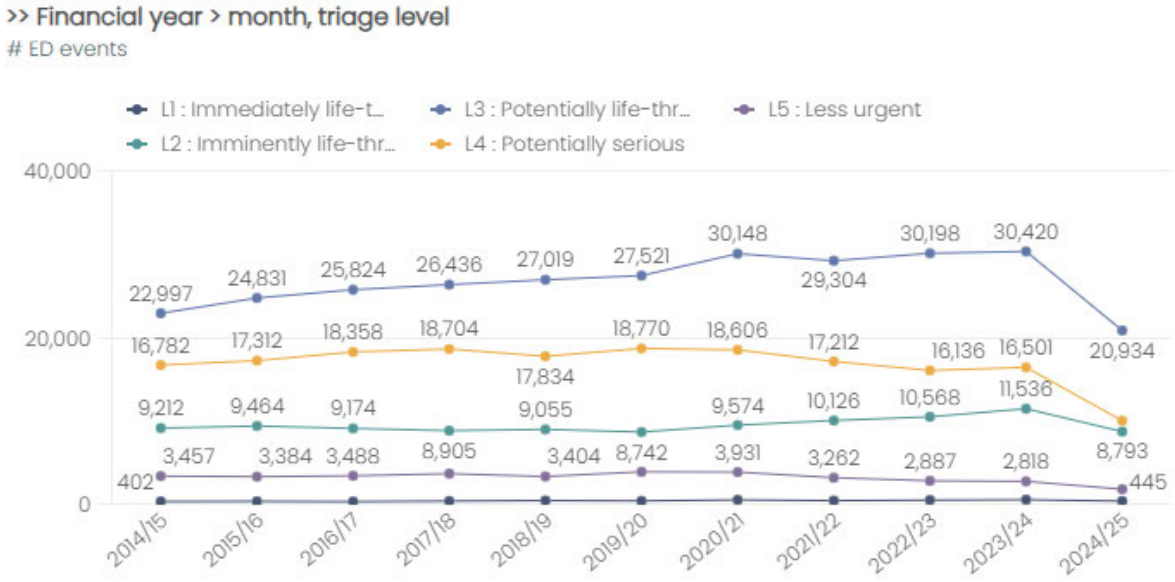
Occupancy, frailty and complexity

10. Higher hospital occupancy over time has led to an increase in patients experiencing access block. In 2014, fewer than 10% of patients admitted to the hospital spent more than eight hours in ED. This had grown to over 50% by last year.

11. Patients spending a very long time in the ED (more than 12 hours) has also risen significantly over the last decade. In 2014/15, 381 patients spent more than 12 hours in the ED, compared to 10,828 patients in 2023/24. Very long stays are more common, with 93 people staying more than 48 hours in 2023/24 compared to none in 2014/15.

12. Patients presenting with increased frailty and complexity drives system flow issues and higher occupancy rates. In 2014/15, 61.7% of patients were triage levels 1-3 (highest needs), compared with 68.8% of patients in the 2023/24 financial year. **Figure 3** below shows the increase in triage L2 and L3 presentations since 2019 and the decrease in L4 and L5. Data for 2024/25 is for part of the year only but shows a similar trend.

Figure 3: Wellington ED presentations by triage level 2014/15 – 2024/25



13. Patients who have increased complexity and frailty take longer to assess and discharge, driving up EDLOS and inpatient LOS. This drives bed blocking – an inability to admit patients to wards – leading to ED overcrowding and delays in assessments and treatment. With a fall in the proportion of patients presenting at triage level 4/5, there is reduced opportunity to immediately shift demand to urgent care or primary and

community services to reduce ED blockages, or to streamline patients through a quicker 'treat and discharge' option.

System flow and capacity

14. Capacity has been well-exceeded and the ability to treat more complex and frail patients has declined. Compared to other EDs, such as Waikato, Christchurch and Auckland, Wellington ED has had no major expansion to its physical space since 2001. These issues are further detailed in the Cabinet paper and Detailed Business Case presented to you on the Wellington ED refurbishment [HNZ00071220 refers].

15. The number of ARC beds available to discharge to in Wellington has fluctuated over time. Regular reviews of the number and types of beds available are undertaken by Health NZ and contractual purchasing adjusted to meet demand. The most recent review in December 2024 resulted in more dementia (+51), hospital-level (+69) and psychogeriatric beds (+5), but fewer rest-home level beds (-58) being required. Once these beds are fully available over the next few months, we expect to see an impact on patient flow.

16. With increasing complexity and frailty, system flow and capacity challenges are being further compounded by the need for – and lack of – experienced clinicians in key ED and acute flow roles.

Future focus - 90-day plan

17. A 90-day plan has been developed to respond to the challenges outlined above and to improve acute flow and SSED performance. Five priority improvement areas have been identified:

    a. **Implement Ambulatory Care stream:** focusing on implementing a new model of care for Treat and Discharge (TAD), with recruitment underway to staff a 24/7 discharge stream. In the interim, the fast-track zone is being staffed for 12 hours of the day within the current resources and is already starting to have some impact on the non-admitted stream of patients.

    b. **Capacity and flow:** reviewing and implementing recommendations on hospital flow, including use of a transit lounge and improving bed turnaround times. Review of the transit lounge and utilisation is underway. A lounge area has also been identified on the medical floor and is being used to support freeing up of capacity in the medical wards prior to 10am to support transfer of patients from ED who are waiting for admission. The Medical Assessment and Planning Unit has been reinstituted to improve access and flow for general medicine patients. Opportunities to further enhance early supported discharge are also being explored.

    c. **Cardiology, cardiac surgery, and cardiothoracic surgery regional pathways:** establishing a programme of priorities for access to these services and reviewing existing models of care This is aimed at improving access to beds for the region and reducing bed-blocking.

    d. **Structure, leadership and operational focus:** recruiting to permanent leadership team roles, establishing 90-day plan programme capacity and capability to support performance improvement and enhancing data and insights to enable smarter

decision-making. Work plans for each key workstream have been developed with key measures identified to monitor effectiveness and improvements. Action with urgency and the need for improvement have been reinforced with daily monitoring and reporting in place to support prompt decision making. Reporting of key metrics has been reviewed to ensure the teams have the right information available on a daily basis to support decision making and actions. Roles and responsibilities relating to managing patient flow are being reinforced to strengthen the operational grip and accountability for performance.

e. **Options appraisal for district-wide requirements for additional bed capacity (medium-term):** assessing options for further regional capacity uplifts, including in Kenepuru (rehab) and Hutt (cardiology/rheumatology/plastics), to reduce demand on Wellington Regional Hospital.

18. The interim CEO has visited the service in recent weeks. As part of the drive to enhance the focus on the lowest-performing districts in the country, he has increased operational leadership support to the service by sending an experienced senior executive to assist with actions to lift performance. That executive arrived two weeks ago and is actively working on implementing the 90-day action plan with local leaders.

19. Implementation of the action plan began in mid-February 2025 and will continue until mid-May 2025, after which Health NZ will determine the priorities to support further improvements. A high-level version of the plan is provided in **Appendix 2**.

20. A programme team is being established to lead implementation, led by the Group Director Operations, Capital Coast and Hutt Valley.

21. Daily reporting is in place to support progress, as is a national dashboard of all ED performance across the country. A weekly progress report is being developed and provided to the Deputy Chief Executive – Central Region.

Next steps

22. Health NZ can provide you with additional information on the Wellington ED 90-day plan at your request. We will continue to provide you with updates on Wellington ED's performance as part of your Weekly Report.

Appendix 1 – 2021/22 Independent review findings

The independent review was undertaken in August 2021 by s 9(2)(a) has extensive experience in reviewing and advising on hospital flow performance.

Use of data and information

While data and information that was available provided a good understanding of what was happening within the hospital and ED, it was not being used effectively. In addition, an enhanced performance monitoring system was essential and should have been designed and implemented with urgency.

Alternative patient pathways

Work should be undertaken to minimise presentations to the Emergency Department and further foster the "ED alternative" by:

- reestablishing an alternate location for Mental Health crisis assessment such as existed during previous pandemic lockdown conditions;
- working with the sector regarding opening hours for community acute care targeting an extension of operations; and
- considering short-term options for housing/facilitating minor acute procedures such that minor procedures which can be safely undertaken at an "ED/front of house level" are not unnecessarily admitted.

Patient flow within the hospital

Using an enhanced performance monitoring system, more urgency should be driven from the Integrated Operation Centre (IOC) to ensure flow across the hospital by:

- ensuring that ED-to-ward transfer is supported by the IOC team and duty managers throughout the 24-hour period to avoid the peaks and troughs of movement more driven in response to bed management meetings;
- ensuring the Medical Assessment and Planning Unit (MAPU) is reinvigorated and enabled to be used solely for its intended purpose, supported by the IOC; and
- establishing clinician-led, management-supported workgroups to drive criteria-led discharge with a particular focus on reducing barriers to safe discharge at the weekend.

Regional coordination

Focus should be on coordinating across the region, with Capital and Coast taking the lead as the main emergency and trauma service. This includes:

- ensuring that all receiving services clearly articulate the regional workup criteria necessary prior to transfer to tertiary services, such that Capital and Coast is not undertaking imaging, diagnostics and such that are available regionally;
- ensuring transport between the regions prioritises discharge from tertiary care; and
- engaging with secondary care regarding the timeliness of accepting discharge from the tertiary facility.

Aged Care

Work should be undertaken to:

- examine bottlenecks around the discharge of the elderly, such as undertaking an inpatient psychogeriatric review and considering what additional resource within and without the region may be available; and
- working with the Aged Care sector to ensure that patients are not unnecessarily admitted for assessments relating to revised levels of community care which could be undertaken in the community.

Utilisation and access to theatres

- With urgency, work is needed to ensure that barriers to the provision of access to acute theatre are minimized. This will enable daily acute theatre capacity to more closely align with demand.