

# Planned Care Taskforce

# Reset and Restore Plan

Confirmed final 2 Sept 2022

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## 1. Purpose of this document

The Reset and Restore plan responds to the requirement for the Planned Care Taskforce to complete a Reset and Restore Plan to provide advice to the Chief Executives of Te Whatu Ora and Te Aka Whai Ora on actions to be taken locally, regionally and nationally to improve equity, increase access and reduce waiting lists for planned care.

## 2. Executive Summary.

Planned care is a continuum for the investigation and management of non-acute symptoms and conditions. Timely access to planned care is central to supporting health and wellbeing. The health reforms, especially the establishment of Te Whatu Ora (Health New Zealand) and Te Aka Whai Ora (the Māori Health Authority), provide the opportunities for more collaboration and consistency in the management and implementation across the planned care continuum at the national and regional levels.

The immediate foci of the Taskforce are:

1. To eliminate the growing inequity of access affecting Māori and Pacific on planned care waiting lists
2. Ensuring high clinical priority care is delivered within clinically acceptable timeframes
3. The elimination of excessively long waiting lists in systematic order with explicit timeframes for attainment
4. Ensure an effective monitoring and evaluation framework is developed

Despite well-established maximum waiting times for various interventions, several thousand people are waiting more than 12 months for access to an array of services, despite a maximal waiting time requirement of four months; and many thousands more are waiting between four and 12 months. Whilst the pandemic, winter illnesses, depleted workforce and resource pressures have dramatically contributed to the long waiting lists, there are also fundamental failings in the historical management system that also contribute to the inefficiencies, inequities, and delays. Whilst coronavirus has had a profound adverse effect, there were deteriorations in the waiting list performance pre-dating the pandemic.

The health reforms offer significant opportunities to work in a far more collaborative and effective way between primary and secondary care, and between districts and regions. There is an imperative to effectively measure and report on progress to ensure such opportunities are being grasped.

The establishment of Te Aka Whai Ora will see the development of programmes specifically designed to improve health outcomes for Māori. The Taskforce recognises the opportunities of Te Aka Whai Ora to materially change the way some aspects of planned care are designed and delivered including via Te Aka Whai Ora's commissioning functions.

Planned care must co-exist with other services and demands within the health system. To reduce the unintended consequences on, or of, the other dimensions of the system, planned care must be more strategic and intentional in developing and utilising protected resources to achieve the desired outcomes. Acute care will continue to be disruptive to planned care services in mixed health facilities. Strategic assets such as purely elective facilities protect planned care capacity and should be further developed along with improved use of private surgical hospitals and specialty facilities.

Entering the planned care continuum can be challenging in itself, let alone navigating the journey for investigations, through to being seen by specialists. For far too long planned care

has required most patients to wait to see a specialist secondary care doctor or to access a service only available via a secondary care doctor.

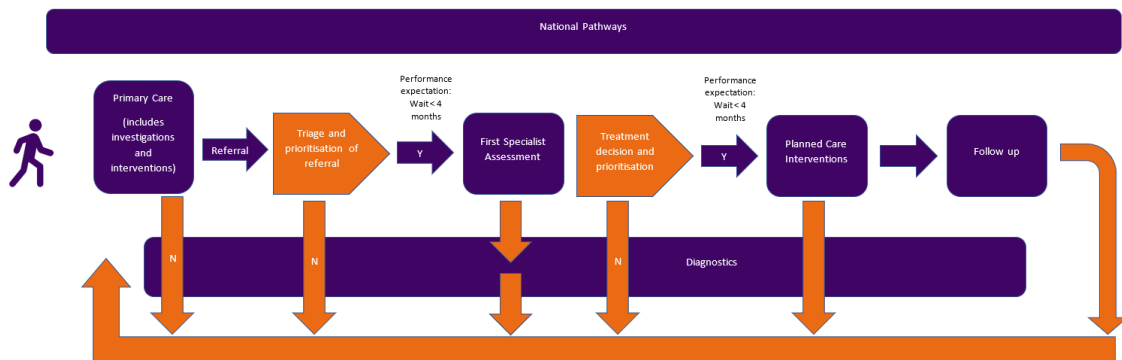
The health workforce must fit the needs of the patients. The Taskforce supports the work of the Workforce Taskforce in developing a coordinated and system-wide approach to recruitment, education, training and retention of the health system workforce. Education and training must support the new models of care developed by Te Whatu Ora.

The Taskforce recognises the considerable opportunities for community health providers, focused in particular on the needs of Māori and Pacific patients. Such opportunities need proper resourcing and support.

There are numerous opportunities for change including:

1. Increasing the utilisation of well trained and highly skilled clinicians in the allied health and nursing workforces to enable model of care changes
2. Improving processes to allow primary care specialists to access the right “next step”
3. Improving processes to allow more planned care within primary care
4. Regulatory changes to enhance the scope of practice for allied health and nursing professionals to perform more planned care, all within their skill set
5. Increasing whanau support (social services/navigators) for the vulnerable populations to navigate the health system
6. Improving support for community health providers especially for Māori and Pacific
7. Improving the use of technology and mobile services to especially aid the inequities of geography affecting many rural and remote communities

Figure 1 The planned care continuum



A significant challenge in establishing a more equitable, sustainable and enduring planned care system is to examine the opportunities to “work smarter, not harder”. This means the Taskforce has looked at the needs of patients and the skills necessary to provide for those needs. This may challenge many existing ways of working and thinking.

In the longer term, the focus will be to imbed a more resilient and efficient system. The system will be responsive to deliver equitable care and improved health outcomes for all New Zealanders.

The Taskforce has explored various opportunities for improvement along the planned care continuum and has made many recommendations for Te Whatu Ora’s consideration. There is

a need to ensure workforce development and distribution is aligned to these opportunities. Given the effects of the pandemic, it is imperative that the advantages offered by the reforms are maximised, especially in regard to inter-district and regional cooperation to benefit both patients and staff.

The plans and measures described are provided as an input into the development of a planned care delivery model which Te Whatu Ora will submit to the Minister of Health and the Government. Further work will be required, building on the content provided in this document, to develop Te Whatu Ora's planned care processes.

Te Whatu Ora will need to determine how it seeks expert advice on the opportunities raised by the Taskforce. Local knowledge of our systems, culture and practices will be essential to this work.

Once the system successfully sees and treats those waiting more than 12 months, it is necessary for Te Whatu Ora to be clear in the next steps. The Taskforce recommends time frames logically move to focusing on those waiting more than nine months and then six months with timelines for achievement to be set by Te Whatu Ora.

The Taskforce acknowledges the "unknown" of the continuing impact of the pandemic both on resources and staffing. Ultimately the health system will need to reset to a new "business as usual" footing as we anticipate on-going admissions due to Covid-19, but without the traditional seasonal variation in numbers typically seen with other viral respiratory illness.

This will mean the total number of admissions to hospital will likely reset at a higher number than our secondary facilities usually plan for or are designed for. In addition, we have likely "reset" expectations for sick leave for health care workers. This will again need to be considered in a new "business as usual model" for the health system. These caveats may affect the delivery of planned care. The impact of international supply chain pressures is also a significant risk to planned care delivery.

### 3. Context

Our health system is large and complex. Unifying our health system to simplify decision-making will result in a system that is nationally led, regionally delivered and locally tailored to ensure local services meet local needs, while also being connected to a nationally consistent range of quality specialist health services. Health equity and Te Tiriti sit at the heart of the health reforms.

Planned care delivery is inter-dependant on the effectiveness of the wider system. Future capacity to support planned care will require strategic investment in infrastructure and workforce. Where scale allows capacity for the provision of planned care, a planned care system protected from the impact of acute demand and associated staffing constraints would enable more effective provision of planned care.

The changes brought about by the restructure of the health system provide an opportunity to eliminate the existing known variation in access to planned care throughout the country, including from an ethnicity-based equity perspective. Removal of arbitrary district boundaries offers both opportunity and need for regional planning and cooperation - it is not acceptable to have “ease of access” in one district whilst another struggles to provide access only for high priority cases. It also provides the ability to work across districts and regions to promote national consistency of access criteria for planned care.

Keys to improved planned care delivery include:

- Identifying and addressing inequities at each point in the planned care continuum
- Strong and consistent clinical governance
- Improved information and patient management systems
- Access to knowledge, investigations and treatments at appropriate points in the planned care continuum
- An engaged and supported workforce
- Consistency in processes including resource utilisation and scheduling
- Improved collaboration with the private sector

This document outlines the current known state of waiting lists, explores opportunities for innovation and improvement and challenges some existing practices. The challenges and opportunities outlined are not exhaustive and as new issues are raised or opportunities are identified Te Whatu Ora is urged to have processes that allow for rapid assessment.

The Taskforce acknowledges that the impact of the pandemic in particular is a “rate limiting step” for staff and resources and therefore timeframes are indicative only. In Appendix A we have given an indication of what we see as the broad priorities *within* the immediate timeframe if we were to be placed in a position of having to stratify the immediate priorities.

The Taskforce also makes various recommendations to seek input from “expert groups”. This means further advice and consideration is recommended to fully determine the applicability and/or development of an opportunity. The nature of that input will naturally vary depending on the circumstances. Expertise exists in many areas and is not restricted to the clinicians who currently provide a service.

### 4. COVID-19 and Planned Care

COVID-19 has been hugely disruptive to hospital systems all over the world. More than two years into the pandemic, global health systems are still facing significant challenges in providing essential health services.

The long tail of the pandemic, in addition to winter acute medical demand and severe constraints on staff capacity are affecting the provision of planned care and consequently waiting lists. It is anticipated that waiting lists will continue to increase in the short to medium-term.

Should the pandemic continue to significantly disrupt the health system the Taskforce recommends a targeted focus on:

- Access for the highest clinical priority cases
- Reduction of excessively long-waiting cases with further focus initially on Māori and Pacific patients
- Ensuring regional cooperation by districts to ensure access is prioritised as above
- Engagement with clinicians to maximise use of available resources – for example the duration of planned care theatre lists
- Engagement with Private providers to improve contracts and access opportunities
- Progressing development of pathways and guidelines to improve clinical consistency
- Progressing work to develop and refine models of care opportunities identified by the Taskforce
- Development of the digital tools necessary for improvement and monitoring
- Development of mobile opportunities for diagnostic and therapeutic services

This focus recognises that staffing is the greatest challenge to improved planned care delivery. A disciplined focus on the management of waiting lists and use of scarce resources is necessary, but at the same time work on matters such as pathway and guideline development should proceed to enable the system to be prepared for improvements when staffing allows.

## 5. Equity

A key reason for the health reforms is an acknowledgement that previous iterations of the health system had failed to alleviate many health inequities. Addressing equity is a core principle of the Pae Ora Act, 2022

Health inequities are unfair, avoidable and remediable. In planned care, an obvious example of a health inequity is that of access whereby differing groups are disproportionately affected by delays. Further areas of health inequity include differences in advice and treatment options offered to patients. Health equity is achieved when health outcomes are equitable to that achieved for others.

An immediate necessity in planned care is to improve timeliness. However, this only addresses some inequity. Whilst the simplest intervention is to adjust timeframes for patients once they are on a planned care waiting list, greater progress is anticipated by moving this focus to make adjustments to timelines at least at the point of entry to the planned care system. This recognises that some patients waiting an excessively long time for access to various interventions have already been disadvantaged earlier in the health system. This is why Te Whatu Ora has instructed that once high clinical priority cases have been addressed, priority must be given to excessively long-waiting patients, with emphasis on the longest waiting Māori and Pacific patients.

Data comparing waiting times at the end of June 2022 with the position at 31 March 2022 shows further deterioration in access across various aspects of planned care with a higher growth in Māori waiting more than 12 months compared with other groups. In Elective Services Patient Flow Indicator (ESPI) 5 for example, the number of Māori waiting greater than 12 months grew by 53% compared with a 49% increase in numbers for non-Māori, non-Pacific and 20% for Pacific. However, the overall percentage of Māori waiting more than 12 months

on ESPI 5 is very similar to non-Māori and non-Pacific at 9.1 and 9.3% respectively, with Pacific at 5%, at the end of June 2022. There is regional variation in these trends.

With regard to compliance with waiting times for Treatment, only 53% of Māori are treated within four months compared with 58% of non-Māori, non-Pacific and 62% of Pacific; again demonstrating inequity especially for Māori.

The health system cannot defend the existence of health inequities and all health professionals have an ethical obligation to work toward eliminating such inequities. It is imperative that data analysis and reporting is performed prospectively to allow identification of health inequities and to track progress on addressing health inequities in each service, district and region.

Monitoring needs to be appropriate to the state of each waiting list:

- At present, monitoring must demonstrate the reduction in inequity especially amongst those patients waiting an excessively long time for any aspect of planned care. As waiting times decrease, a similar focus must move to the next time bracket of the waiting list.
- Further development of strategies to adjust for inequities as patients “enter” the planned care system are being developed. In the longer term, once waiting times have recovered, prospective monitoring of ethnicity is important to assess the effectiveness of any “inequity adjustment” as patients enter planned care.

Outcomes may vary and some of this variation may represent inequity. It is therefore important to consider this issue when examining outcomes in the health system. The reporting of outcomes should recognise the value of describing any ethnicity differences.

The Taskforce noted that for initiatives to be applicable in our health system the issue of the effects of any innovations on inequity (positive or negative) especially for Māori and Pacific must be considered.

The Taskforce notes the recommendation from the Health and Disability System Review that the system needs to “be well informed by population health data and have the capability to interpret this information, respond decisively to emerging trends and health threat and understand where to direct further action”<sup>[1]</sup>.

Achieving the necessary outcomes for Māori requires that funders, planners and services in the health system have access to appropriate and meaningful data. This should inform the collection, analysis and interpretation of health information to create actionable intelligence for planned care. Completing a parallel exercise for Pacific health data to level 2 ethnicity, is a critical priority for Pacific equity.

Ola Manuia is the Pacific Health Plan to 2023 and is part of Te Pae Tata, the New Zealand Health Plan. The priorities in that plan include a focus on families, community care and Pacific provider development. Working with navigation services from primary and community into the hospital system for planned care is a long-term objective. Sustaining gains in the reduction of long waiters is a priority.

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<sup>[1]</sup> HDSR final report 2020, p96



Expectations for delivering equity must be set both for the system as a whole and for the professionals within it.

There are numerous examples of inequities in many planned care services. Various interventions have been trialled. Culturally appropriate health navigation and support services are necessary if the health system is to truly address inequity.

Access is but one part of addressing inequity. Other than timeliness, analysis of variation by ethnicity is required when examining investigations and treatments offered and, most importantly, the outcomes achieved. Where identified, expert review is recommended to determine if the differences represent a health inequity. Where the differences do identify an inequity, initiatives must be put in place to resolve this.

The Taskforce notes the pandemic and associated deterioration in planned care has severely impacted a health system that was already under-performing for Māori. The Taskforce is committed to recommendations that ensure that our planned care response is pro-equity. We expect that all actions will be assessed in terms of this objective.

**The Taskforce recommends:**

- Examination of data to determine the extent to which interruption to planned care has disproportionately affected Māori. Lessons from this process should be used to strengthen plans to avoid such disruption in the future
- Confirm an explicit prioritisation framework if delay/cessation of any services are required: Services for Māori must be the last to be stopped in any priority band
- Confirm an explicit prioritisation framework for restarting services that have been deferred: Services for Māori should be the first services restarted in each priority band
- Services should reorient to meet the needs of Māori including interventions such as redeploying existing staff or using alternative locations to deliver services
- Te Whatu Ora must monitor, report and act upon impacts on equity for Māori from the pandemic, and specifically outline how Te Tiriti obligations will be met throughout planned care reset and restart
- Reduction of excessive waiting times of Pacific must be specifically reported
- Immediate action to ensure ethnicity is accurately collected and presented in accordance with Health Information Standards Organisation (HISO) standards
- For Pacific equity, community and family focussed models for care navigation should be investigated (community out into hospitals)
- Data and evidence that specifically identify where inequity exists in the pathway for Pacific peoples should be made visible at a system level for action. This could include deep dives, for example into diagnostics, ophthalmology, urology and paediatric dental delays with a focus initially on the Northern Region in particular given the location of large Pacific populations
- Long term investments in workforce are interrelated to planned care challenges and sustainable funding to secure the Pacific workforce of the future is required across the system.

## **5.1. Challenging Existing Policies and Processes**

The Taskforce has identified variations that need challenging as Māori and Pacific in particular are often unfairly disadvantaged due to a higher population prevalence of certain conditions:

- There are variable “rules” to the upper limit for Body Mass Index (BMI) for some surgical interventions. It is important that there is consistency based on clinical risk and

relative benefit. The Taskforce also notes that there is considerable debate as to direct applicability of BMI to all patients

- Similarly, the Taskforce is aware of differences in access depending on diabetic control as measured by Haemoglobin A1c (HbA1c). Whilst acknowledging the importance of good diabetic control to reduce risk, there is a need for national consistency
- Smoking status is clinically important; however it should not be used as a blanket tool to deny access unless there is clear evidence of the futility of treatment in a particular circumstance. Where such evidence exists, it is important to therefore offer smoking cessation assistance.

The Taskforce notes that there are legitimate clinical safety reasons to limit case mix in some facilities based on resources but “blanket” barriers to access in a district or region based purely on factors such as BMI, HbA1c and smoking status are not acceptable.

There are varying policies and attitudes to the re-scheduling or not of patients who for whatever reason do not attend a planned care appointment. There must be national consistency of both the policy and response to issues of “did not attend” within each specialty or service, depending in particular on the clinical circumstances of the case. There is evidence that many patients are unable to attend an appointment as opposed to choosing not to attend. There must be a nationally consistent approach to “did not attend” for a planned care event. Furthermore, in most specialties “did not attend” rates show disproportionately high numbers of Māori and Pacific. Specific policies and support processes must be developed specific to Māori and Pacific rather than simply declining a further appointment.

**The Taskforce recommends:**

- Immediate action to establish expert working groups to achieve national consistency the way that BMI, HbA1c and smoking are managed within the delivery of planned care
- Te Whatu Ora should develop nationally consistent policies regarding “did not attend”. These policies must include the role of cultural support/culturally appropriate health navigation services.

### **Summary of recommendations section 5 Equity**

- Examination of data to determine the extent to which interruption to planned care has disproportionately affected Māori. Lessons from this process should be used to strengthen plans to avoid such disruption in the future
- Confirm an explicit prioritisation framework if delay/cessation of any services are required: services for Māori must be the last to be stopped in any priority band
- Confirm an explicit prioritisation framework for restarting services that have been deferred: services for Maori should be the first services restarted in each priority band
- Services should reorient to meet the needs of Māori including interventions such as redeploying existing staff or using alternative locations to deliver services
- Te Whatu Ora must monitor, report and act upon impacts on equity for Māori from the pandemic, and specifically outline how Te Tiriti obligations will be met throughout planned care reset and restore
- Reduction of excessive waiting times of Pacific is specifically reported
- Immediate action to ensure ethnicity information is accurately collected and presented in accordance with HISO standards
- Immediate action to establish expert working groups to achieve national consistency the way that BMI, HbA1c and smoking are managed within the delivery of planned care
- Te Whatu Ora should develop nationally consistent policies regarding “did not attend”. These policies must include the role of cultural support/culturally appropriate health navigation service
- For Pacific equity, community and family focussed models for care navigation should be investigated (community out into hospitals)
- Data and evidence that specifically identifies where inequity exists in the pathway for Pacific peoples should be made visible at a system level for action
- Long term investments in workforce are interrelated to planned care challenges and sustainable funding to secure the Pacific workforce of the future is required across the system.

## 6. Current State Analysis – Planned Care Overview

The Planned Care Taskforce has used a range of data sources to establish a current state view of planned care performance and delivery over time. It has been very challenging to establish a complete view of planned care across the specialist/hospital services system as there is incomplete or inadequate information for diagnostic waiting lists to support meaningful analysis, there is a lack of ethnicity data in all national collections and national reported waiting list information, and data held in the national patient flow data repository are not complete and do not appear to have had systematic data quality checks applied over time.

Te Whatu Ora has limited data analytics capability and capacity to assess the performance of the planned care system and is reliant on sourcing information from the Ministry of Health on an ad hoc basis currently. As a matter of priority there is a need to establish an appropriate data governance and data quality function, and associated systems, within Te Whatu Ora to ensure improved data quality in national collections that will enable effective measurement and monitoring of all elements of hospital and specialist services planned care.

### **The Taskforce recommends that Te Whatu Ora:**

- Reviews the existing data analytics capability and capacity available within Te Whatu Ora to support the ongoing requirements of measuring and monitoring the performance of planned care delivery across the hospital and specialist services system
- Reviews the ongoing requirements for national data governance and data quality management systems to provide assurance of the quality and completeness of national collections data to support future decision-making being informed by robust and complete data
- Reviews planned care performance monitoring frameworks and updates to include routine reporting of metrics by ethnicity
- Establishes a mechanism that provides visibility of compliance with national collections reporting requirements by district and develops a framework that provides feedback to support continuous improvement in data quality and completeness.

### 6.1. Referrals

The planned care journey typically begins with a visit to a health professional, this is most often a General Practitioner, but also includes other community-based clinicians such as a community dental provider or optometrist, an emergency department, inpatient service, or a private specialist, who decides to refer a patient for care by a public hospital specialty. There are also growing numbers of community Māori and Pacific health providers.

The following table (Table 1) provides a trend over time of referrals accepted and seen over the last four calendar years, and for the 12 months to March 2022. These data, sourced from the Ministry of Health National Patient Flow (NPF) data repository, are not considered to be a complete representation of all referrals for specialist care and some caution is needed in assessing this information and what it can tell us.

Assuming there is consistency in the collection of this information over the time period indicated, it does show there is a gap each year between the number of referrals accepted and the number of referrals seen (refer Table 2) and this shows that this has been the case since prior to COVID-19. Note that during 2020 the gap between referrals accepted and referrals seen was significantly higher and this is consistent with what we might expect given the impact of the COVID-19 pandemic and associated national lockdowns that significantly impacted usual activity in hospitals across the country.

**Table 1: Number of referrals accepted and referrals seen by calendar year + 12 months to March 2022**

Data source: MOH NPF KPIs

	Referrals Accepted					Referrals Seen				
	2018	2019	2020	2021	Mar-22	2018	2019	2020	2021	Mar-22
<b>Northern</b>	16,768	17,210	18,555	17,436	19,254	14,495	14,842	16,401	15,254	15,927
<b>Midland</b>	9,193	8,698	10,926	9,747	10,312	7,812	7,984	8,837	8,405	8,794
<b>Central</b>	7,820	9,564	12,179	10,824	11,187	6,883	7,845	9,308	9,152	10,739
<b>Southern</b>	8,760	9,382	11,154	10,436	10,556	7,245	8,089	8,546	8,927	10,271
<b>NZ Total</b>	<b>42,541</b>	<b>44,854</b>	<b>52,814</b>	<b>48,443</b>	<b>51,309</b>	<b>36,435</b>	<b>38,760</b>	<b>43,092</b>	<b>41,738</b>	<b>45,731</b>

**Table 2 – Difference between referrals accepted and referrals seen**

Data source: MOH NPF KPIs

Difference between referrals received and seen					
	2018	2019	2020	2021	Mar-22
<b>Northern</b>	2,273	2,368	2,154	2,182	3,327
<b>Midland</b>	1,381	714	2,089	1,342	1,518
<b>Central</b>	937	1,719	2,871	1,672	448
<b>Southern</b>	1,515	1,293	2,608	1,509	285
<b>NZ Total</b>	<b>6,106</b>	<b>6,094</b>	<b>9,722</b>	<b>6,705</b>	<b>5,578</b>

## 6.2. Radiology

There is no national collection of outpatient Radiology waiting lists by ethnicity, by district or by priority for all high volume outpatient radiology modalities (Computed Tomography(CT), Magnetic Resonance Imaging(MRI), US (Ultrasound), Xray). National reporting is limited to a combined count of the number of patients on the waiting list in the month and the outpatient MRI and CT procedures completed within a particular month and within six weeks. This means at any point in time we are unable to identify the count of patients on radiology waiting lists from the nationally available data. Therefore, the Taskforce is unable to quantify the size of the waiting list to reliably establish what additional MRI, CT, and US volumes need to be delivered, and the capacity required, to achieve recovery to compliance with national diagnostic waiting time indicators.

Further work is needed as a priority to establish routine reporting of all high volume modalities (MRI, CT, US) by priority and ethnicity and waiting times. More detailed waiting list information is available in the Northern region for MRI, CT and ultrasound and this reporting shows there are both ethnicity and geographical inequities within the region and 37% of all patients waiting for these outpatient radiology modalities are waiting outside the recommended waiting times.

The following table provides a summary of the CT and MRI national data available, and shows that:

- Prior to the COVID-19 pandemic in December 2019 nationally 71% of patients were waiting fewer than six weeks for outpatient CT against a national indicator of 95%, and 59% of patients were waiting fewer than six weeks for outpatient MRI against a national indicator of 90%
- In June 2022, the CT position has marginally improved with 76% of patients waiting fewer than six weeks and the MRI position has also marginally improved to 63% of patients waiting fewer than six weeks.

**Table 3: Outpatient Radiology CT and MRI waiting times December 2019 – June 2022**

*Data Source: MOH Diagnostics Indicator web tool*

CT SCAN									
Region	Waiting or Scanned < 42 days			CT Waiting and Scanned			% in 42 Days or Less		
	Dec 2019	Dec 2021	Jun 2022	Dec 2019	Dec 2021	Jun 2022	Dec 2019	Dec 2021	Jun 2022
Northern	3799	3995	4008	5981	5388	5355	64%	74%	75%
Te Manawa Taki	2760	2675	2792	3906	3192	3536	71%	84%	79%
Central	2248	2574	3188	3359	3644	5019	67%	71%	64%
South Island	3807	4272	4418	4634	4492	5021	82%	95%	88%
<b>Grand Total</b>	<b>12614</b>	<b>13516</b>	<b>14406</b>	<b>17880</b>	<b>16716</b>	<b>18931</b>	<b>71%</b>	<b>81%</b>	<b>76%</b>
MRI SCAN									
Region	Waiting or Scanned < 42 days			MRI Waiting and Scanned			% in 42 Days or Less		
	Dec 2019	Dec 2021	Jun 2022	Dec 2019	Dec 2021	Jun 2022	Dec 2019	Dec 2021	Jun 2022
Northern	2598	3015	3027	4890	5727	5333	53%	53%	57%
Te Manawa Taki	1880	2035	2301	2686	2927	2910	70%	70%	79%
Central	1243	1718	1773	2272	3205	2874	55%	54%	62%
South Island	1931	2218	2418	3074	3481	3893	63%	64%	62%
<b>Grand Total</b>	<b>7652</b>	<b>8986</b>	<b>9519</b>	<b>12922</b>	<b>15340</b>	<b>15010</b>	<b>59%</b>	<b>59%</b>	<b>63%</b>

### 6.3. Endoscopy

The Ministry of Health has historically reported national waiting times by priority bands for colonoscopy only; however, the current national data capture is limited to reporting percentage compliance against national waiting time indicators for procedures completed in a particular month combined with the number of patients on the waiting list, and is therefore not a true measure of the count of patients waiting for a procedure. There is no ethnicity reporting.

The Taskforce is unable to quantify the size of the waiting list to reliably establish what additional volume of colonoscopy procedures and gastroscopy procedures need to be delivered, and the capacity required, to achieve recovery to compliance with national colonoscopy waiting time indicators.

There is no national reporting of gastroscopy waiting lists and waiting times and the information that is available in some districts shows that for both colonoscopy and gastroscopy procedures there is a significant number of patients waiting outside recommended waiting times. The data that are available in the Northern region suggest that outpatient colonoscopy procedures delivery has been prioritised over the delivery of gastroscopy procedures and this might have been influenced by the requirements for colonoscopy symptomatic waiting list improvement associated with the national bowel screening rollout.

The following table provides a summary of the colonoscopy position nationally by region against compliance with national targets:

- 87% of patients for urgent (P1) colonoscopy in June 2022 compared with 91% in December 2019, against a national target of 90% within 14 days
- 55% of patients for non-urgent colonoscopy (P2) in June 2022 compared with 51% in December 2019, against a national target of 70%



- 58% patients for surveillance colonoscopy in June 2022 compared with 54% in December 2019 against a national target of 70%.

**Table 4: Outpatient Colonoscopy waiting times December 2019 – June 2022**

Data Source: MOH Diagnostics Indicator web tool

Urgent Colonoscopy									
Region	Waiting or Scoped < 14 days			Total Waiting or Scoped			% in 14 Days or Less		
	Dec 2019	Dec 2021	Jun 2022	Dec 2019	Dec 2021	Jun 2022	Dec 2019	Dec 2021	Jun 2022
Northern	238	246	237	246	252	245	97%	98%	97%
Te Manawa Taki	142	192	168	150	206	186	95%	93%	90%
Central	96	116	99	116	131	126	83%	89%	79%
South Island	104	95	83	128	125	115	81%	76%	72%
<b>Grand Total</b>	<b>580</b>	<b>649</b>	<b>587</b>	<b>640</b>	<b>714</b>	<b>672</b>	<b>91%</b>	<b>91%</b>	<b>87%</b>
Non-Urgent Colonoscopy									
Region	Waiting or Scoped < 42 days			Total Waiting or Scoped			% in 42 Days or Less		
	Dec 2019	Dec 2021	Jun 2022	Dec 2019	Dec 2021	Jun 2022	Dec 2019	Dec 2021	Jun 2022
Northern	2040	1840	2039	3545	3685	3936	58%	50%	52%
Te Manawa Taki	1009	1393	1318	2218	1969	1831	45%	71%	72%
Central	768	773	765	1587	1603	1674	48%	48%	46%
South Island	1033	775	854	2236	1521	1551	46%	51%	55%
<b>Grand Total</b>	<b>4850</b>	<b>4781</b>	<b>4976</b>	<b>9586</b>	<b>8778</b>	<b>8992</b>	<b>51%</b>	<b>54%</b>	<b>55%</b>
Surveillance Colonoscopy									
Region	Waiting or Scoped < 84 days			Total Waiting or Scoped			% in 84 Days or Less		
	Dec 2019	Dec 2021	Jun 2022	Dec 2019	Dec 2021	Jun 2022	Dec 2019	Dec 2021	Jun 2022
Northern	1472	1549	1876	2298	3221	3415	64%	48%	55%
Te Manawa Taki	577	581	728	1089	782	979	53%	74%	74%
Central	752	791	937	1649	1461	1745	46%	54%	54%
South Island	746	2010	1735	1514	3213	2904	49%	63%	60%
<b>Grand Total</b>	<b>3547</b>	<b>4931</b>	<b>5276</b>	<b>6550</b>	<b>8677</b>	<b>9043</b>	<b>54%</b>	<b>57%</b>	<b>58%</b>

## 6.4. First Specialist Assessment (FSA) waiting lists – ESPI2

In December 2019, prior to the COVID-19 pandemic 12,894 patients (11%) on FSA (ESPI 2) waiting lists were waiting more than four months and 253 patients were waiting more than 12 months. By June 2022 there are 18,274 more people on FSA waiting lists and 35,264 patients (25%) are waiting more than four months. There are now 4,255 patients waiting more than 12 months in June 2022 compared with 253 patients in December 2019. The data made available to the Taskforce and sourced from MOH to support this analysis do not contain ethnicity data to enable assessment of inequity within the ESPI 2 waiting list.

The following table provides a summary of the ESPI-2 waiting list position by region from December 2019 - June 2022. The proportion of patients waiting more than four months has not deteriorated in the last six months; however the number of patients waiting more than 12 months has more than doubled.

**Table 5: FSA waiting lists by region from December 2019 – June 2022**

*Data source: MOH Qlik National Booking Reporting System(NBRS) ESPI2*

	FSA	Dec-19	Dec-21	Mar-22	Jun-22	Change	
						Dec 19 - June 22	
<b>Northern region</b>	<b>Total</b>	<b>48295</b>	<b>49391</b>	<b>53484</b>	<b>57761</b>	<b>9466</b>	<b>20%</b>
	> 4 months	3677	13887	14326	15245	11568	315%
	%	<b>8%</b>	<b>28%</b>	<b>27%</b>	<b>26%</b>		
	> 12 months	25	247	587	1575	1550	
	%	<b>0.1%</b>	<b>1%</b>	<b>1%</b>	<b>3%</b>		
<b>Te Manawa Taki</b>	<b>Total</b>	<b>25318</b>	<b>32099</b>	<b>32299</b>	<b>31354</b>	<b>6036</b>	<b>24%</b>
	> 4 months	3694	9475	10290	9486	5792	157%
	%	<b>15%</b>	<b>30%</b>	<b>32%</b>	<b>30%</b>		
	> 12 months	66	1273	1300	1312	1246	
	%	<b>0.3%</b>	<b>4%</b>	<b>4%</b>	<b>4%</b>		
<b>Central</b>	<b>Total</b>	<b>22582</b>	<b>24392</b>	<b>24200</b>	<b>22915</b>	<b>333</b>	<b>1%</b>
	> 4 months	2479	3628	4837	3898	1419	57%
	%	<b>11%</b>	<b>15%</b>	<b>20%</b>	<b>17%</b>		
	> 12 months	24	194	209	348	324	
	%	<b>0.1%</b>	<b>1%</b>	<b>1%</b>	<b>2%</b>		
<b>Southern</b>	<b>Total</b>	<b>24094</b>	<b>26819</b>	<b>26204</b>	<b>26533</b>	<b>2439</b>	<b>10%</b>
	> 4 months	3044	6360	7008	6635	3591	118%
	%	<b>13%</b>	<b>24%</b>	<b>27%</b>	<b>25%</b>		
	> 12 months	138	263	554	1020	882	
	%	<b>0.6%</b>	<b>1%</b>	<b>2%</b>	<b>4%</b>		
<b>NZ Total</b>	<b>Total</b>	<b>120289</b>	<b>132701</b>	<b>136187</b>	<b>138563</b>	<b>18274</b>	<b>15%</b>
	> 4 months	12894	33350	36461	35264	22370	173%
	%	<b>11%</b>	<b>25%</b>	<b>27%</b>	<b>25%</b>		
	> 12 months	253	1977	2650	4255	4002	
	%	<b>0.2%</b>	<b>1%</b>	<b>2%</b>	<b>3%</b>		

## 6.5. Outpatient delivery – FSA and Follow up

A review of Medical and Surgical specialist outpatient clinic activity over a three-year period between calendar year (CY) 2019 and CY 2021 shows that there was a 1% reduction in the total number of first specialist assessments (FSA) delivered and a 2% increase in follow-ups (FU) delivered nationally.

### 6.5.1. FSA

Based on January – June 2022 actual FSA volume delivery annualised; it is forecast that there will be 10% (n = 60,150) fewer FSAs delivered in 2022 compared to 2021. The same analysis of follow up activity identifies a year end forecast position of 5% (n = 77,637) fewer FU delivered. The level of follow up reduction is half that of the FSA reduction.

### 6.5.2. Follow up

There is no routine reporting of follow up waiting lists nationally so we are unable to measure or assess the impact of the reduced level of follow ups delivered in the first six months of 2022. We are also unable to assess the extent to which overdue follow ups may be a cause of concern requiring additional focus in the prioritisation of planned care delivery and recovery.



**Table 6: FSA and follow-up delivery 2019 – 2021 calendar year, 2022 YTD extrapolated**

Data source: NNPAC

Attendance by Region	2019	2020	2021	2022 *	Growth 2019-2021	% Annual Growth	Growth 2021-2022	% Annual Growth
<b>Total FSAs</b>	<b>599152</b>	<b>560142</b>	<b>587762</b>	<b>527612</b>	<b>-11390</b>	<b>-1%</b>	<b>-60150</b>	<b>-10%</b>
Northern	217409	214638	227080	201302	9671	2%	-25778	-11%
Te Manawa Taki	122745	116580	123533	116554	788	0%	-6979	-6%
Central	120156	106146	109088	97578	-11068	-5%	-11510	-11%
South Island	138842	122778	128061	112178	-10781	-4%	-15883	-12%
<b>Total FollowUps</b>	<b>1371930</b>	<b>1374494</b>	<b>1422989</b>	<b>1345352</b>	<b>51059</b>	<b>2%</b>	<b>-77637</b>	<b>-5%</b>
Northern	499452	525957	545676	509570	46224	5%	-36106	-7%
Te Manawa Taki	264630	269100	275381	263724	10751	2%	-11657	-4%
Central	289486	267745	281947	268778	-7539	-1%	-13169	-5%
South Island	318362	311692	319985	303280	1623	0%	-16705	-5%

The deterioration in FSA volume delivery is highlighted.

### 6.5.3. Follow up to FSA ratio

The following table provides a summary of follow-up to FSA ratio over time and this shows that across all regions nationally there has been an increase in the number of follow ups delivered relative to the number of FSA delivered. Over the same time period there has been fewer acute and elective inpatient care delivered and it is therefore difficult to explain why follow up activity has continued to grow.

**Table 7: Follow up to FSA ratio 2019-2022**

Data source: NNPAC

	2019	2020	2021	2022
NZ total	2.29	2.45	2.42	2.55
Northern	2.3	2.45	2.4	2.53
Te Manawa Taki	2.16	2.31	2.23	2.26
Central	2.41	2.52	2.58	2.75
South Island	2.29	2.54	2.5	2.7

### 6.5.4. Opportunities to increase FSA delivery

The following table provides a summary of the opportunities to increase FSA delivery, should we return to the levels of activity in 2019 prior to the COVID-19 pandemic disrupted capacity and the usual ways of working:

- If FSA volume delivery returned to 2019 levels, there would be 71,540 more FSA delivered nationally than is currently forecast in 2022
- If the FU to FSA ratio was reduced to the regional 2019 ratio there would be 139,308 fewer Follow Ups (FU) delivered, and this released capacity could be used to deliver 46,436 more FSAs (assuming an FSA takes three times longer than a follow up).

**Table 8: Impact of FSA and FU volume delivery returning to levels consistent with 2019 pre COVID-19 levels**

Data source: NNPAC

Increase FSA volumes back to 2019 (preCOVID) volumes		Reduce FuP/FSA ratio to 2019 (preCOVID) baseline, convert	
	FSA		FU
Northern	16107	Northern	-47120
Te Manawa Taki	6191	Te Manawa Taki	-12441
Central	22578	Central	-33688
South Island	26664	South Island	-46058
<b>NZ Total</b>	<b>71540</b>	<b>NZ Total</b>	<b>-139308</b>

Analysis of virtual FSA and virtual follow up activity (Table 9) as a proportion of all FSA and follow up shows that:

- There is generally consistent use of virtual FSA nationally except in Te Manawa Taki where there may be an opportunity to increase the use of virtual FSA to enable a proportion of the associated specialist's time to be released to undertake other clinical activity.
- A review of virtual follow up activity shows there is no consistency in the use of this alternative to in-person follow up assessment nationally. If all regions achieved a nationally consistent rate of 7% virtual follow ups (Table 10), this would reduce the number of in-person follow ups by 48,217 and in so doing would release a proportion of the associated specialist's time to undertake other clinical activity.

**Table 9: Proportion of FSA and Follow up that are virtual**

Data source: NNPAC

	% FSA that are virtual				% Followup that are virtual			
	2019	2020	2021	2022	2019	2020	2021	2022
<b>NZ total</b>	<b>12%</b>	<b>12%</b>	<b>13%</b>	<b>14%</b>	<b>2%</b>	<b>3%</b>	<b>3%</b>	<b>3%</b>
Northern	12%	13%	15%	15%	5%	7%	7%	6%
Te Manawa Taki	6%	5%	7%	9%	1%	1%	0%	1%
Central	13%	18%	16%	16%	0%	0%	0%	1%
South Island	14%	12%	14%	14%	1%	1%	3%	3%

**Table 10: In-person follow up volume reduction associated with 7% virtual rate**

Data source: NNPAC

Increase % Virtual FuP's to 7%, convert inperson capacity to FSAs	
	FU
Northern	-3782
Te Manawa Taki	-16155
Central	-17192
South Island	-11088
<b>NZ Total</b>	<b>-48217</b>

**The Taskforce recommends:**

- Te Whatu Ora considers setting minimum FSA delivery volumes and follow up to FSA ratios consistent with 2019 actuals to support increased delivery of FSA and reductions in follow ups
- Te Whatu Ora considers setting minimum virtual follow up volumes to release capacity to support other clinical activity
- Consideration is given to extending Ophthalmology overdue follow up reporting to all follow ups to enable ongoing monitoring and improvement.

## **6.6. Treatment – ESPI5:**

An early part of the work undertaken by the Taskforce was to establish a national view of the ESPI 5 position by district and region to create a baseline using March 2022 national data from which to measure, monitor and manage performance going forward. The following summarises the national position in June 2022 and while we know that all districts have been impacted by increased hospitalisations and the advent of winter illnesses, this summary shows that:

- There has been a 6% increase in the total number of patients on ESPI 5 waiting lists and 7% increase in the number of patients waiting more than four months.
- There are now 28,530 patients (42% total waiting list) waiting more than four months and the Northern region is the only region where ESPI compliance has improved over the last three months.
- There are 5,555 patients waiting more than 12 months and this is an increase of 1,832 more people compared with three months ago and has occurred in all four regions.
- There has been an inequitable increase in patients waiting more than 12 months with a 53% increase in the number of Māori waiting more than 12 months compared to 49% for all populations and 20% for Pacific.
- In order to achieve a waiting list position where most patients receive treatment in four months the desired months' forward load (MFL) is three. The current waiting list position is equivalent to 5.2 months' forward load and 29,381 additional volumes would need to be delivered to reduce this to 3 months.
- While there is insufficient workforce and capacity to carry out this work immediately, if it were possible to procure the capacity required to provide this work, the cost of these additional volumes is estimated at \$231M and this has increased by \$31M in the last three months (noting the cost of these volumes are expressed in 2021/22 national WIES prices). Te Whatu Ora has advised very recently that the 2022/23 national WIES price uplift is 7% and the revised cost of these volumes is \$247M.
- The COVID-19 Response Recovery Fund has provided \$70M in 2022/23 to lift the levels of planned care delivery following the disruption caused by COVID-19.

**Table 11: ESPI 5 waiting list position March 2022 – June 2022**

			Change March - June 2022	
	Mar-22	Jun-22	volumes	%
<b>ALL NZ</b>				
Total on ESPI 5 waiting list	64071	68215	4144	6%
Total waiting more than 4 months	26577	28530	1953	7%
% waiting more than 4 months	41%	42%		1%
<b>MFL</b>	4.9	5.2	0.3	
Total additional volumes to achieve MFL = 3	25411	29381	3970	16%
Additional Volume at 21/22 WIES Price	\$200,511,880	\$231,834,875	\$31,322,995	16%
Total waiting more than 12 months	3723	5555	1832	49%
Total Maori waiting more than 12 months	695	1065	370	53%
Total Pacific waiting more than 12 months	177	212	35	20%
			Change March - June 2022	
			volumes	%
<b>Northern</b>	<b>Mar-22</b>	<b>Jun-22</b>		
Total on ESPI 5 waiting list	22186	22404	218	1%
Total waiting more than 4 months	9207	8545	-662	-7%
% waiting more than 4 months	41%	38%		-3%
Total waiting more than 12 months	1109	1590	481	43%
<b>Te Manawa Taki</b>	<b>Mar-22</b>	<b>Jun-22</b>	<b>volumes</b>	<b>%</b>
Total on ESPI 5 waiting list	14560	16006	1446	10%
Total waiting more than 4 months	5666	6729	1063	19%
% waiting more than 4 months	39%	42%		3%
Total waiting more than 12 months	590	1019	429	73%
<b>Central</b>	<b>Mar-22</b>	<b>Jun-22</b>	<b>volumes</b>	<b>%</b>
Total on ESPI 5 waiting list	12779	13882	1103	9%
Total waiting more than 4 months	5372	6234	862	16%
% waiting more than 4 months	42%	45%		3%
Total waiting more than 12 months	927	1329	402	43%
<b>Southern</b>	<b>Mar-22</b>	<b>Jun-22</b>	<b>volumes</b>	<b>%</b>
Total on ESPI 5 waiting list	14546	15923	1377	9%
Total waiting more than 4 months	6332	7022	690	11%
% waiting more than 4 months	44%	44%		1%
Total waiting more than 12 months	1097	1617	520	47%

### Inpatient Planned Care Service Delivery

The 31 May 2022 Aide Memoire to the Chief Executives of Te Whatu Ora – Health New Zealand and the Māori Health Authority identified that prior to the COVID-19 pandemic in the calendar year 2019 there were 162,479 elective planned care discharges delivered. In 2020 and 2021 there were fewer elective discharges delivered and for the rolling 12-month period to March 2022 there was a further reduction in activity. The following table provides a summary of the volumes delivered by specialty for the period April 2022 - June 2022 and this shows that 86% of expected volumes were delivered nationally. This varied by region with Central and Southern delivering 80% of expected volumes and the Northern region 94% of expected volumes. It is understood that this can be attributed to the impact of COVID-19 hospitalisations

and the advent of winter illness demands impacting available hospital capacity to support planned care delivery.

**Table 12: Summary of Elective Inpatient Planned Care Volumes by Region April 2022 – June 2022**

Region	April - June 2022 Inpatient Volumes (data extracted 25th July 2022)													Total	% of "normal"
	Dental	Cardio	General Surgery	CardioTx	ENT	Gynae	Neuro	Ophthal	Ortho	Paed Surgical	Plastics	Urology	Vascular		
	D01.01	M10.01	S00.01	S15.01	S25.01	S30.01	S35.01	S40.01	S45.01	S55.01	S60.01	S70.01	S75.01		
Northern	775	800	2436	148	1426	1143	133	2967	1539	203	566	969	175	13280	94%
Te Manawa Taki	561	530	1401	84	497	577	79	1312	845	131	419	465	130	7031	85%
Central	549	381	1182	86	460	718	70	1097	767	162	470	470	153	6565	80%
South Island	346	404	1209	86	670	680	62	1321	843	137	592	628	180	7158	80%
<b>NZ Total</b>	<b>2231</b>	<b>2115</b>	<b>6228</b>	<b>404</b>	<b>3053</b>	<b>3118</b>	<b>344</b>	<b>6697</b>	<b>3994</b>	<b>633</b>	<b>2047</b>	<b>2532</b>	<b>638</b>	<b>34034</b>	<b>86%</b>
% of "normal"	98%	88%	85%	90%	74%	81%	81%	104%	74%	77%	81%	98%	77%	86%	

The following two tables provide a summary of patients on the elective inpatient planned care surgery and treatment waiting lists by clinical service.

Table 13 shows that more than 50% of Orthopaedic and Vascular patients are waiting more than four months for surgery. There are 7243 Orthopaedic patients waiting more than four months for surgery and Orthopaedic patients represent 25% of all patients waiting more than four months nationally.

**Table 13: Number of ESPI 5 patients waiting more than four months by clinical service June 2022**

Region	Current ESPI 5 Non Compliant (Waiting longer than 4 months)													Total	% of Waitlist
	Dental	Cardio	General Surgery	CardioTx	ENT	Gynae	Neuro	Ophthal	Ortho	Paed Surgical	Plastics	Urology	Vascular		
	D01.01	M10.01	S00.01	S15.01	S25.01	S30.01	S35.01	S40.01	S45.01	S55.01	S60.01	S70.01	S75.01		
Northern	621	34	1420	36	866	854	101	837	2669	197	128	698	84	8545	38%
Te Manawa Taki	913	190	1013	19	660	796	37	606	1532	201	372	289	101	6729	42%
Central	575	27	1593	37	551	414	36	856	1172	78	299	481	115	6234	45%
South Island	205	305	1033	48	1280	345	48	834	1870	95	403	261	295	7022	44%
<b>NZ Total</b>	<b>2314</b>	<b>556</b>	<b>5059</b>	<b>140</b>	<b>3357</b>	<b>2409</b>	<b>222</b>	<b>3133</b>	<b>7243</b>	<b>571</b>	<b>1202</b>	<b>1729</b>	<b>595</b>	<b>28530</b>	<b>42%</b>
% of WL	47%	23%	40%	33%	46%	43%	37%	33%	54%	45%	29%	37%	51%	42%	

Table 14 below shows the number of patients waiting more than 12 months and there has been a 49% increase in this number since March 2022. Just over half (n = 2947) of all patients waiting more than 12 months are on Orthopaedic and General Surgery waiting lists.

**Table 14: Number of ESPI 5 patients waiting more than 12 months by clinical service June 2022**

Region	Current ESPI 5 Long Waiters (Waiting longer than 12 months)													Total	% of Waitlist
	Dental	Cardio	General Surgery	CardioTx	ENT	Gynae	Neuro	Ophthal	Ortho	Paed Surgical	Plastics	Urology	Vascular		
	D01.01	M10.01	S00.01	S15.01	S25.01	S30.01	S35.01	S40.01	S45.01	S55.01	S60.01	S70.01	S75.01		
Northern	106	0	163	1	48	236	22	54	671	41	24	210	14	1590	7%
Te Manawa Taki	209	9	115	6	107	124	2	82	201	28	44	70	22	1019	6%
Central	30	2	540	2	50	80	0	95	368	9	40	87	26	1329	10%
South Island	47	57	334	18	242	37	12	129	555	8	79	24	75	1617	10%
<b>NZ Total</b>	<b>392</b>	<b>68</b>	<b>1152</b>	<b>27</b>	<b>447</b>	<b>477</b>	<b>36</b>	<b>360</b>	<b>1795</b>	<b>86</b>	<b>187</b>	<b>391</b>	<b>137</b>	<b>5555</b>	<b>8%</b>

Clinical risk potentially exists at each point where there is excessive waiting. This risk varies between services and between differing diagnostic categories. Risks will exist whilst awaiting clinic review, diagnostic procedures and therapeutic interventions. This is why accurate knowledge of the waiting lists for each part of the planned care continuum and active management of waiting lists are essential to improving patient safety.

Broad risk issues include, but are not limited to:

- First specialist assessment: Delays in establishment of diagnosis, treatment plans
- Follow-up: Deterioration of chronic health conditions requiring secondary care oversight; failure to conduct adequate surveillance for various conditions
- Diagnostic Services: Delays in establishing the diagnosis to allow appropriate treatment and to establish clinical timeframes for treatment
- Therapeutic interventions: Deterioration in quality of life on non-urgent waiting lists.

#### **Summary of recommendations – Section 6 Current State Analysis – Planned Care Overview**

- Review existing analytics capability and capacity available within Te Whatu Ora to support measuring and monitoring planned care delivery across the system
- Review the ongoing requirements for national data governance and data quality management systems to provide assurance of the quality and completeness of national collections data
- Review planned care performance monitoring frameworks and updates to include routine reporting of metrics by ethnicity
- Establish a mechanism that provides visibility of compliance with national collections requirements, and provide feedback to support continuous improvement in data quality
- Consider setting minimum FSA delivery volumes and follow up to FSA ratios
- Consider setting minimum virtual follow up expectations
- Consider extending Ophthalmology overdue follow up reporting to all services

## 7. Interventions recommended by the Taskforce

The immediate priorities are to improve access, improve the oversight and management of the existing waiting lists and to ensure greater efficiency in the system, whilst also progressing work that will create a far more sustainable and equitable planned care system. These priorities are designed to address unacceptable clinical risk and to reduce inequities.

Based on the information identified, and where national data are available, the Taskforce has evaluated the national status and direction of key planned care measures. There are opportunities for intervention at various points in the planned care continuum, however the applicability of any intervention does need to be relevant to the Aotearoa New Zealand context.

Key actions have been developed that are expected to make a material difference in reducing the backlog of planned care by improving access and thus improving aspects of equity. These actions, along with a range of recommendations communicated prior to development of this plan, are included in this Reset and Restore Plan. Recommendations in this plan are summarised in Appendix A.

The Taskforce has received information on many opportunities. Some of these recommendations can be confidently recommended while others will require more detailed review to ensure confidence in feasibility and effectiveness to determine true applicability across the health system and to ensure no unintended effects, especially on equity. It is also important to note that some initiatives can be expanded in some areas now, whilst their general national applicability is determined. Opportunities may currently exist in some districts or regions that can be increased in an iterative and sustained way. We should encourage this, whilst at the same time assessing national applicability.

Expert advice will be needed where a fundamental change to current practice is considered to ensure clinical safety and appropriateness is maintained. Furthermore, innovations that involve primary care in particular will require fundamental changes to how aspects of primary care are funded.

The Taskforce recognises the considerable workforce challenges across the sector. A coordinated investment in, and recovery of, the workforce is essential to maximise the opportunities the Taskforce has identified.

Any advance in the scope of planned care provided in General Practice must not worsen access for other primary care needs. This is likely to be a major rate limiting step in achieving the maximal benefit from any primary care initiative at least in the medium-term future.

There are opportunities and needs to intervene at all parts of the planned care continuum:

- Consistency of terminology
- Improved and expanded clinical pathways
- Expansion of interventions in primary and community settings
- Diagnostics
- Handling of specialist referrals
- Treatments including improved working with the private sector
- Management of follow-ups
- Consistency in processes including resource utilisation and scheduling



**The Planned Care Continuum**

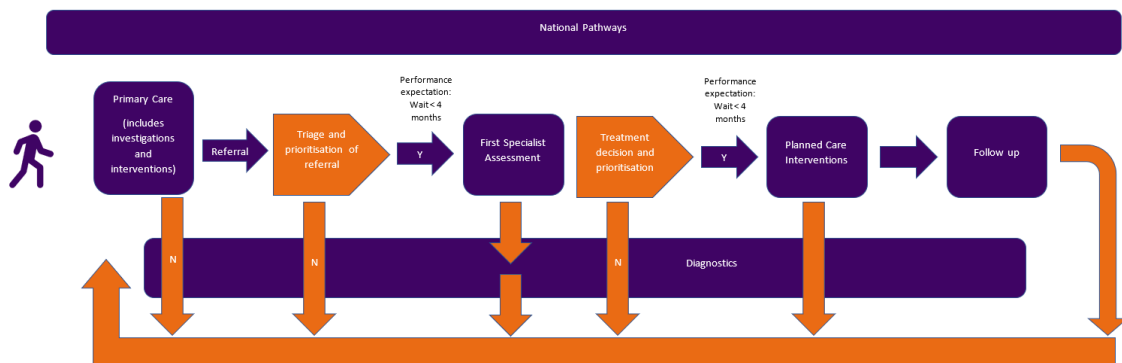
Planned care occurs at various points in the health system and opportunities exist to improve access, reduce inequity and improve outcomes at multiple points in this continuum.

The Taskforce recognises the need to look at system improvements at all points along this continuum. There is a need for immediate interventions as well as for the introduction over a longer-term period of changes that will embed a more resilient, equitable, and sustainable system for the provision of planned care.

The planned care continuum depicted below demonstrates the current planned care pathway for many patients *if their care needs assistance from outside of primary care*. The Taskforce recognises a considerable amount of “non-secondary” planned care already occurs in primary and community health services. The Taskforce supports workforce development and any necessary funding changes to allow improved access and delivery of these services.

The innovations and initiatives reported below are designed to improve access, improve timeliness and reduce and eliminate many of the inequities present in the current system.

The Taskforce has focussed its work on all components of planned care to identify opportunities to be considered within this Reset and Restore Plan.



*The planned care continuum*

Ensuring equity of access is served best by improvements beginning as early in the planned care continuum as possible. Other determinants of equitable outcomes include consistency of advice and treatment options; these require strong clinical insight and input. The Taskforce notes there are opportunities to better utilise allied health and specialist nurse roles in a variety of areas where the decision to utilise allied health or specialist nursing can be made either via agreed clinical pathways and accessed at primary care or at the point of referral triage or after FSA assessment or a diagnostic test. This recognises that some clinical pathway options can only be determined after FSA and /or investigations and that circumstances vary in terms of determining the most appropriate strategy depending on the clinical circumstances.

**Summary of recommendations - the planned care continuum**

- Work to be done to ensure clarity on opportunities for improved clinical pathways involving allied health or specialist nursing roles
- Workforce development must align with models of care



## 7.1. Unmet Need

There is no effective measure of unmet need. However, it is important to develop systems and processes to at least better inform the health system of this issue.

Simple measures include:

- “Decline rates” for referrals (although this will not address the question of the appropriateness of the referral)
- Treatment thresholds
- Intervention rates

What is not measurable at present is any decision “not to refer” where that decision was made on the presumption of a denial of access being the outcome.

Progress on measuring unmet need must include ethnicity data and be reported by specialty for districts and regions.

### Summary of recommendations 7.1 Unmet Need

- Te Whatu Ora develop tools to assess unmet need. It is vital that accurate ethnicity and location data be collected to allow for identification of variances that can then be addressed

## 7.2. The “Post-code lottery”

### 7.2.1. The “Post-code lottery”

The Taskforce notes there are considerable inter-district variations in thresholds for planned care. The Taskforce recognises that much of this variation is driven by capacity constraints, but the health reforms mean the system must now work toward national consistency. Prioritisation must be consistent but in addition the national plans must be developed to achieve consistence of access within the prioritisation frameworks ultimately adopted for each condition. The Taskforce is aware, for example, of progress toward regional consistency for cataract surgery in one region where an agreed minimum clinically necessary priority score has been agreed.

#### The Taskforce recommends:

- Nationally consistent prioritisation systems are required. The Taskforce notes work is underway at regional level and national Chief Operating Officers(COO) level to address this. Immediate action is recommended
- Te Whatu Ora works with clinical experts to define agreed minimum access thresholds for various conditions and works toward national capacity for such access recognising this will be a long-term objective.

#### Key mid to longer-term actions include:

- Acute capacity must be right sized to avoid the frequent disruption of the system’s ability to carry out planned care

- Where scale allows, develop capacity for the provision of planned care that is protected from the impact of acute demand and associated staffing constraints.

**Summary of recommendations 7.2 The “Post-code lottery”**

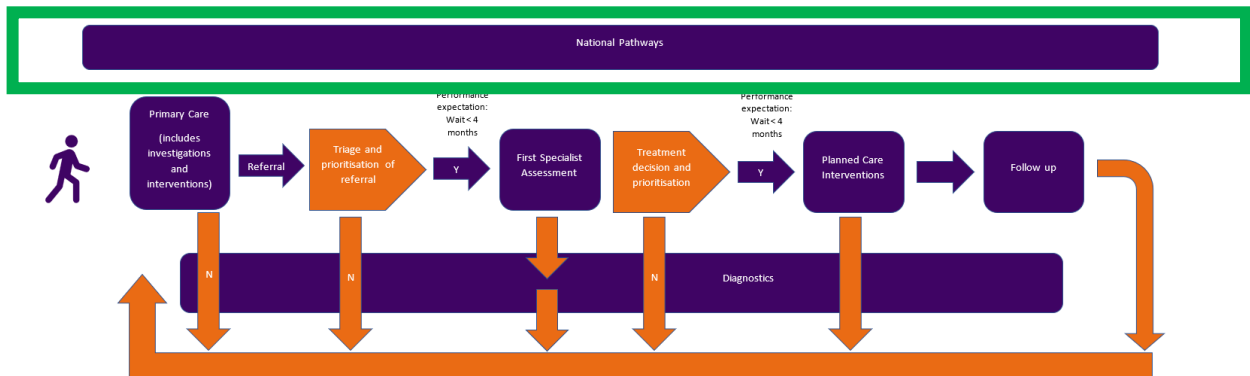
- Nationally consistent prioritisation systems are required. The Taskforce notes work is underway at regional level and national COO level to address this. This is recommended as an immediate priority
- Te Whatu Ora work with clinical experts to define agreed minimum access thresholds for various conditions and work toward national capacity for such access.

In the mid to long term

- Acute capacity must be right sized to avoid the frequent disruption of the system’s ability to carry out planned care
- Where scale allows, develop capacity for the provision of planned care, that is protected from the impact of acute demand and associated staffing constraints.

**Opportunities to improve the Planned Care Continuum**

**7.3. Improved and Expanded Clinical Guidance**



Clinical consistency is crucially important to improving many aspects of care from effective flow both into and out of specific aspects of the health system, through to improved clinical outcomes. Opportunities exist to improve guidance for clinicians at various points in the planned care continuum.

Clinical pathways aid navigation of the health system. Te Whatu Ora has established a pathways group. The Taskforce recognises the need to review the effectiveness and appropriateness of existing guidelines and pathways, and to develop new tools to aid practice across the planned Care continuum.

**Summary of recommendations 7.3 Improved and Expanded Clinical Guidance**

- Agreed pathways and guides should be developed across the continuum
- Where nationally validated management guidelines for a condition have been developed these should be referenced as having been consulted and appropriately followed when referring to secondary services

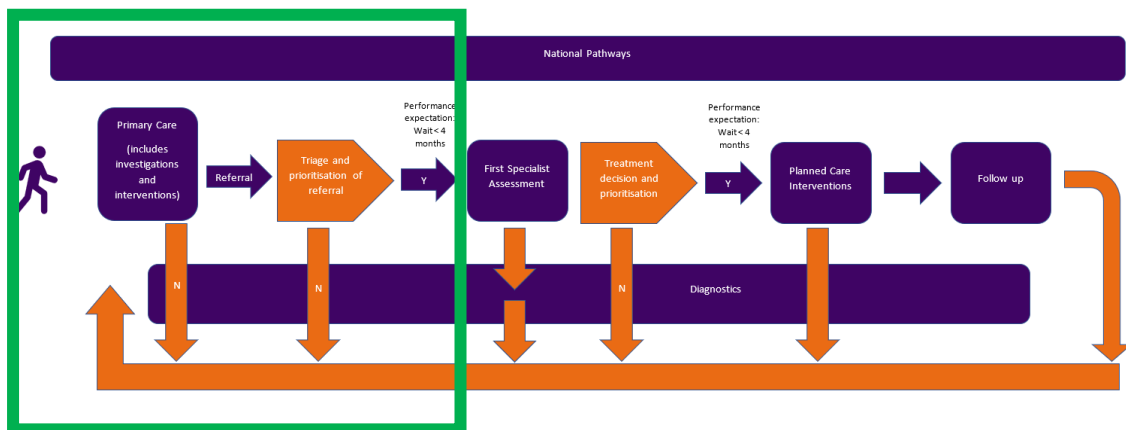
## 7.4. Interventions: Terminology

There is an immediate need to have nationally consistent language as to clinical priority for waiting lists for first specialist assessments and interventions. Some exists; for example, “priority 2” for the symptomatic colonoscopy waiting list, but there is wide variation in many others. This consistency is not only for the priority of various conditions, but also for the acceptable maximal clinical waiting time for any case within a particular priority band.

### Summary of recommendations 7.4 Terminology

- Te Whatu Ora establishes national consistency in the terminology used for prioritisation as an immediate priority

## 7.5. Interventions Prior to Secondary Care



Most patients enter planned care at primary care with escalation to secondary care the most common path if the presenting complaint requires further investigation or management.

There are opportunities to allow for alternatives to the current referral patterns to secondary care. These opportunities are noted under *Interventions: Primary Care* (section 7.6, below) and *Improving Timeliness for Diagnostics, and First Specialist Assessment – opportunities for change* (section 7.10, below).

## 7.6. Interventions: Primary Care

The current funding arrangements for primary care do not lend themselves to significant innovation across all of primary care. However, there are significant opportunities to improve the ability of primary care to access services for patients, especially those requiring diagnostic services or assessment for various conditions. These opportunities are outlined by the Taskforce, noting that some districts are already utilising various aspects of these opportunities.

The Taskforce notes considerable opportunities to expand existing services for Māori and Pacific via Māori or Pacific focused providers. Culturally-based services have been shown to improve access and engagement with health services. The Taskforce acknowledges Te

Whatu Ora is working with Te Aka Whai Ora to further expand and support culturally based health services for Māori and Pacific.

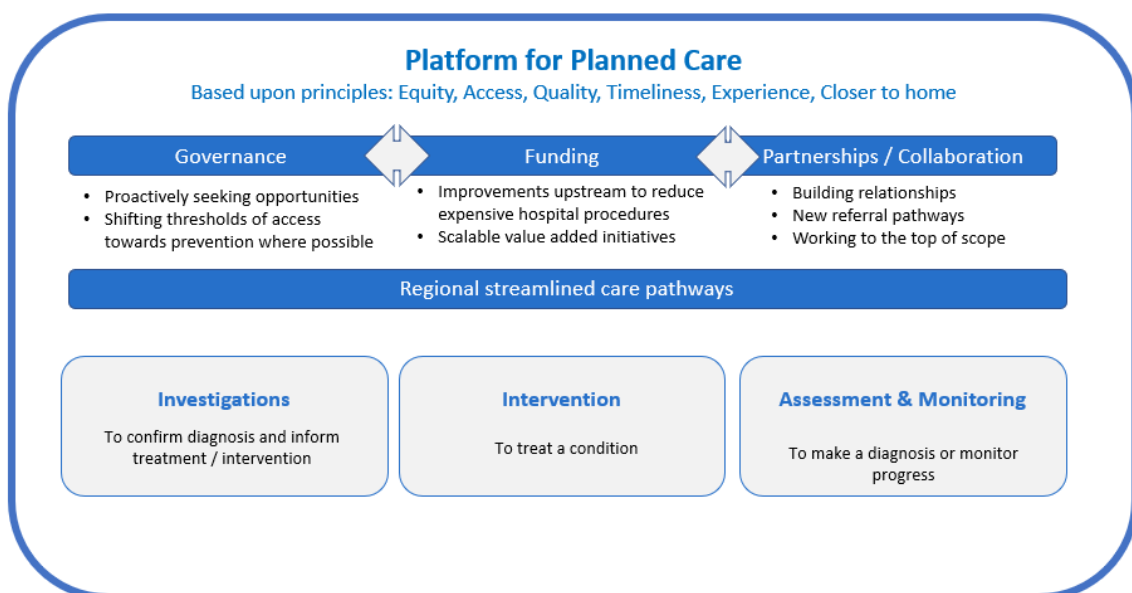
To develop opportunities to allow greater planned care *within* General Practice a Primary Care Working Group was formed to inform the Taskforce.

The Taskforce notes opportunities to provide more effective access for General Practice to what have been traditionally services only accessible via secondary care.

Data from primary care relating to planned care are more difficult to capture centrally than data from hospital services. It is particularly difficult to demonstrate the level of unmet secondary planned care need experienced by patients given General Practitioners know that some referrals will not meet the current threshold for access to secondary services.

The working group has noted there is a significant range of innovation that has been implemented in local pockets that will deliver more value if taken up nationally.

This model below provides a view of the types of pathways where improvements can be made and what actions are required to achieve improvement.



Some clinical pathway options can only be determined after FSA and /or investigations – for instance, pelvic floor physiotherapy may be beneficial for a variety of conditions, some of which require secondary assessment prior to diversion from surgery to physiotherapy, whereas it may well be appropriate for primary care to have greater direct access to pelvic floor physiotherapy for some other conditions.

**The Taskforce recommends:**

- Work be done with various expert groups to ensure clarity of opportunities available from improving clinical pathways that have been developed in some districts but are not used universally around New Zealand. This recognises that circumstances vary in terms of determining the most appropriate pathway.

It is envisaged that the further development of pathways and clarity of the benefits of allied health will allow primary care to directly refer appropriate cases to allied health. Some examples are given under “*Triage, prioritisation and management of referrals for FSA*” below.

Specific to primary care, the working group has identified the following examples of actions which are supported by the Taskforce, acknowledging national applicability needs confirmation where noted.

## Improved Access for Primary Care to Diagnostic Imaging

Diagnostic imaging is essential to decision making in many clinical scenarios.

The improved ability to request and access diagnostic imaging will improve timeliness to diagnosis and aid decision making in a variety of circumstances. This should improve clarity in regard to which patients require FSA at secondary care level for a variety of conditions and therefore improve flow into secondary assessment and treatment. There are existing arrangements in various districts and regions which improve access and timeliness. There are opportunities to expand this activity especially via clinical guidelines and pathways.

Improved access also includes the necessity to have services as conveniently located as possible. The Taskforce notes the opportunity to develop mobile facilities for various modalities.

### **The Taskforce recommends:**

- Pathways and facilities that make access to diagnostic imaging easier should be prioritised in each region.

This work links with work on guidelines and clinical pathways

## Better integrated processes allowing for changes in models of care

At present, General Practitioners often must refer patients to secondary care for investigations and management of symptoms simply because there is a lack of a more clinically integrated process that should be accessible to primary care.

Two examples given here would allow for improved processes for patients assessed and managed in primary care. Note: There are other examples given under “*First Specialist Assessment – opportunities for change*” (section 7.10, below) which are opportunities to improve the ability of General Practice to directly refer to other services in a more effective manner than is currently the case in most services.

### **7.6.1. Primary Care Pathway for Abnormal Uterine Bleeding**

Increasing waiting times exist in a number of districts for access to gynaecology first specialist assessment for abnormal uterine bleeding. Some patients in this group may have significant pathology including uterine malignancy.

- Rates of endometrial cancer are much higher especially amongst Pacific women – ensuring timely, more convenient diagnosis and treatment will likely have a significant equity effect.
- This intervention would reduce total demand for secondary care gynaecology review and improve timeliness of access for patients with abnormal bleeding. At present the sole reliance on secondary gynaecology assessment is delaying diagnosis of those women who potentially have significant pathology. Those patients in whom significant pathology is detected would likely reach secondary FSA in a more clinically acceptable timeframe under a revised pathway. Data to date for women assessed via the agreed primary care pathway in one District show that over 15 months 694 women were assessed by credentialed General Practitioners via this pathway and approximately 50% did not require subsequent referral to secondary care

**What is required?**

- A nationally consistent, funded, pathway
- Primary care access to radiology (most commonly ultrasound)
- Access to gynaecology specialist advice and training. Training, credentialling and oversight to maintain quality of service delivery and care will be provided by secondary care gynaecologists in partnership with primary care
- The credentialed General Practitioner(GP) will potentially perform an endometrial pipelle biopsy and refer the patient for a trans-vaginal ultrasound through a local radiology provider for the convenience of the patient
- As well as the pipelle biopsy, interventions in primary care include long acting reversible contraception (LARC) insertion and iron transfusion.

**The Taskforce recommends:**

- Te Whatu Ora assesses the opportunity to roll out the primary care pathway for abnormal uterine bleeding to other districts and regions.

**7.6.2. Primary Care Assessment and Treatment of Urinary Incontinence and Prolapse**

Urinary incontinence and pelvic floor prolapse is common and waiting times for specialist review are long. Whilst rarely due to a life-threatening illness, symptoms of urinary incontinence and prolapse have major debilitating effects on quality of life.

The Taskforce notes that planned care service improvement projects have piloted approaches to the assessment and treatment of urinary incontinence and prolapse in women.

At present there are inconsistent access points for women with urinary incontinence. These include via gynaecology or urology services or via allied health. As a result, there are district and regional variations that waste time and resources. Improvements via appropriate pathway development will allow more timely and effective access for women. Coupled with this is a need for the two main specialist groups (urology and gynaecology) to cooperatively develop greater clinical consistency including in the application and interpretation of bladder function tests.

One approach piloted in Counties-Manukau has been to train and fund General Practitioners to size, fit and follow up ring pessaries. This releases some capacity within hospital specialist services while providing treatment closer to home for women, often in a clinical setting that they are familiar with.

Another approach piloted successfully in Canterbury has involved physiotherapists assessing women already on the waiting list seeking treatment for urinary incontinence or prolapse – and in the future assessing referrals on arrivals from primary care. Following assessment women are, where appropriate, offered conservative care, including the fitting of pessaries. Some 30% of women provided with this service have been discharged without needing to see a senior medical officer.

**The Taskforce recommends:**

- That approaches to the assessment of urinary incontinence and prolapse are further assessed with a view to developing a national pathway for the initial assessment and treatment of urinary incontinence and prolapse if the benefits are proven.

**7.6.3. Moving Secondary Procedures into Primary Care**

The Taskforce is aware of various opportunities some General Practitioners wish to explore. These opportunities need development in partnership between primary and community Care



Commissioning and established secondary and tertiary service providers. Some of these opportunities may best be delivered under a “GP with Special Interest” model.

#### **7.6.4. Such opportunities could include:**

- Long acting reversible contraception/ Mirena
- Non-melanomatous skin lesion excision and other minor surgical procedures
- Medical termination of pregnancy
- Diabetic retinal screening
- Community infusions, many of which would be advised by secondary care but implemented in primary care, for example:
  - Iron
  - Monoclonal antibodies – infliximab etc
  - Blood products – blood / intragam P
  - Zolendronic acid / aclasta.

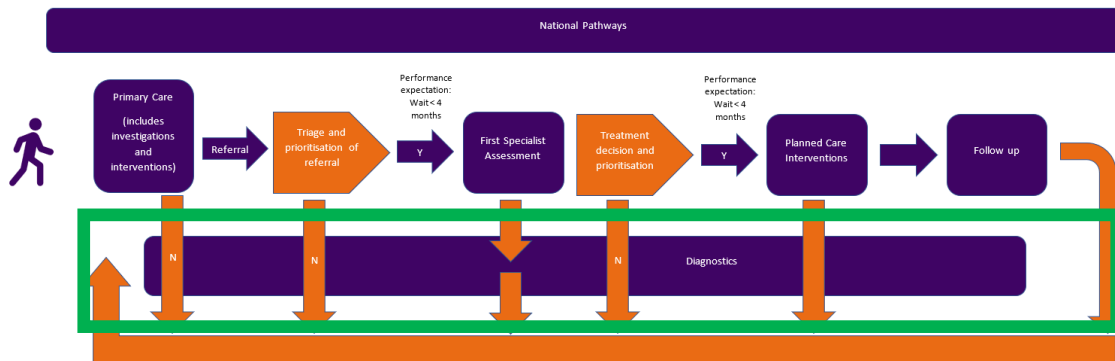
#### **The Taskforce recommends:**

- Regions consider the opportunities provided by moving the named range of services into the community - noting some may be easier to establish than others and therefore a variable timeline is acknowledged.

#### **Summary of recommendations 7.6 Interventions: Primary Care**

- Work be done with various expert groups to ensure clarity of opportunities available from improving clinical pathways recognising that circumstances vary in terms of determining the most appropriate pathway
- Development of processes that make access to diagnostic imaging easier should be immediately prioritised in each region
- Te Whatu Ora assesses the opportunity to roll out the primary care pathway for abnormal uterine bleeding to all districts and regions
- That approaches to the assessment of urinary incontinence and prolapse are further assessed with a view to developing a national pathway
- Consider the opportunities provided by moving the named range of services into the community.

## 7.7. Improving Timeliness for Diagnostics



In addition to improving “direct referral” practice for primary care to diagnostic services, there is also a need for diagnostic services to address excessive waiting times for many patients especially for radiology and endoscopy. Advantages for improving access at primary care have been outlined above. There are also opportunities for improving access for patients across the continuum.

There is an immediate need to implement changes in various areas:

## 7.8. Endoscopy

### 7.8.1. Roll out the FIT for symptomatic referrals pathway

At present, the symptomatic “non-urgent” pathway (“P2”) is generally under significant pressure and clinical risk exists due to delays in meeting the waiting time requirements. There is an appreciable risk of bowel cancer amongst patients on the P2 waiting list, hence why ideally P2 colonoscopies are to be performed within 42 days (with a maximum waiting time of 90 days).

International evidence, supported by local review coordinated by the Ministry of Health and the National Cancer Agency endorses the use of Faecal Immunochemical Testing (FIT) to better stratify the symptomatic, priority 2, waiting list.

A FIT used for the P2 symptomatic pathway would help stratify those with bowel symptoms who are referred for and listed to have a diagnostic colonoscopy. Symptomatic patients, with a positive FIT would be provided with increased priority for colonoscopy compared to a FIT negative patient of the same priority.

There are however important issues to be considered and mitigated:

- Māori and Pacific patients have lower uptake of FIT testing for bowel cancer screening than other ethnicities
- The Taskforce notes FIT for stratifying the symptomatic waiting list has not been specifically validated in Māori or Pacific Island people populations. Unless explicit pro-equity actions are undertaken to ensure that this intervention is safe for these groups and that they have equitable access to receipt and completion of the tests, there is real risk FIT for symptomatic will increase inequity. Similar issues are associated with the



bowel screening program and the solutions are likely transferrable between the two programs

- Any measures to increase capacity which utilise discriminatory selection need to be safe for Māori and Pacific peoples and when in doubt, these groups should be offered clinical assessment
- It is important to note that not all cancers bleed all the time and therefore a negative FIT test cannot in itself “exonerate” the bowel of a patient with symptoms. Similarly, a patient who chooses not to participate may still harbour serious pathology.

It is important to note that FIT testing to re-prioritise the P2 waiting list does not mean the demand for colonoscopy is reduced – it is a tool designed to allow prioritisation of, but not exclusion from, the waiting list. Whilst some jurisdictions have gone further and use FIT for determining the need for a colonoscopy, this is not the intent of the current plans here.

The National Colonoscopy Workforce expert group has developed a plan for rollout by the end of 2022. This group includes clinical advisors from the national executive of the specialty groups of colorectal surgery, gastroenterology, and general surgery. The national plan does involve a pilot in Waikato, which is underway. Specific outcomes of this pilot include ensuring equity of uptake of the programme and learnings will inform the national approaches.

**The Taskforce recommends:**

- Implementation of the FIT for symptomatic pathway should continue as an immediate priority, noting the caveats regarding equity
- Te Whatu Ora should continue to seek advice about any other opportunities in the approach to symptomatic endoscopy referrals from the use of FIT in the longer term.

**7.8.2. Improved Use of Endoscopy Capacity**

The complexity of interventions in endoscopy has increased significantly and this work generally requires both specific expertise and increased time. Such cases are broadly not suitable to outsourcing and therefore need timely access to public endoscopy services. This should be planned on a regional basis to both ensure efficiency and best outcomes.

There is therefore a need to ensure resource use is as efficient as possible and to consider the endoscopy case mix compared with the site of delivery.

Currently those patients who require a colonoscopy through the Bowel Cancer Screening pathway must have that colonoscopy performed by an accredited endoscopist in a public facility. The Taskforce sees no reason why the same accredited endoscopist could not perform the colonoscopy in a private facility. This would increase public facility access for other aspects of the endoscopy waiting list.

Rural communities face greater access challenges than others for endoscopy services. There may be a role for more mobile capacity.

**The Taskforce recommends:**

- That provision of screening endoscopy by accredited endoscopists in a private facility be explored with the National Bowel Cancer Screening unit.

**7.8.3. Endoscopy Workforce**

- The development of the endoscopy workforce is vital to sustainably increasing endoscopy capacity. This should include assessment of both medical and nursing endoscopy opportunities.

**The Taskforce recommends:**

- The further development of the endoscopy workforce is an immediate priority.

**7.8.4. Improve Data and Treatment Targets for Endoscopy**

There is a requirement for improved endoscopy data to aid planning and delivery. In addition, there is no waiting time indicator for gastroscopy. The Taskforce notes significant clinical risk exists for patients overdue for symptomatic gastroscopy as it does for colonoscopy.

There are potential equity issues in the overdue gastroscopy waiting lists given the genetic predisposition of some Māori to gastric cancer.

**The Taskforce recommends:**

- Development of a national dataset that enables identification of all patients on colonoscopy and gastroscopy waiting lists
- Establishment of waiting time indicators for gastroscopy and recording of these in the national dataset.

**Summary of recommendations 7.8 Endoscopy**

- Implementation of the FIT for symptomatic pathway should continue as an immediate priority, noting the caveats regarding equity
- Te Whatu Ora should continue to seek advice about any other opportunities in the approach to symptomatic endoscopy referrals from the use of FIT in the longer term
- Provision of screening endoscopy by accredited endoscopists in a private facility be explored with the National Bowel Cancer Screening unit
- Prioritise the development of the endoscopy workforce
- Explore options for mobile provision of endoscopy (medium to long term)
- Development of a national dataset that enables identification of all patients on colonoscopy and gastroscopy waiting lists
- Establish waiting time indicators for gastroscopy with recording of these in the national dataset.

## **7.9. Radiology**

Excessive waiting times for imaging delay diagnosis and treatment, and delays in surveillance imaging risk effective follow-up of various conditions.

The Taskforce is aware of data showing a disproportionate number of Māori and Pacific patients are waiting excessively long for urgent imaging in some districts. There are examples of effective support services in some districts to aid especially Māori and Pacific patients to access services. Such services are endorsed by the Taskforce.

A series of actions are necessary. Much can be achieved through the establishment of a Radiology Clinical Network (building on the established National Radiology Advisory Group NRAG) and its engagement in planning, prioritisation framework development and rollout, development of national or regional waiting lists, and an improved understanding of whether services meet the clinical requirements necessary at district and local levels.

Advice has been provided to the Taskforce from current leaders of NRAG and with additional resourcing there are immediate opportunities to:

- Undertake work with the support of the Cancer Control Agency to rationalise cancer follow up which places a significant demand on radiology capacity
- Rationalise and standardise incidentaloma follow-up nationally, to reduce variation and the demand for related planned imaging follow-up, and the clinical work that goes along with coordinating this
- Standardise primary care access to imaging via nationalising key health pathways that use imaging.

Maternity ultrasound places significant demand on public outpatient radiology services and this impacts on capacity availability for all other clinical conditions. The level of the current Section 88 maternity fee paid to private providers is insufficient and requires a self-funded co-payment which is cost prohibitive for some individuals. This in turn limits access and use of available private capacity which leads to time-bound requests for publicly provided maternity ultrasounds displacing other patients of equivalent clinical priority.

**The Taskforce recommends:**

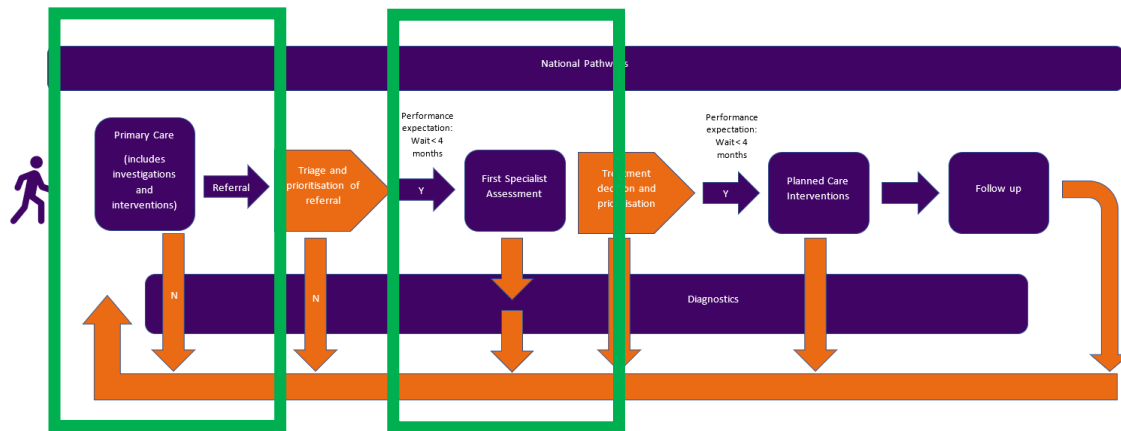
- The Section 88 fee for maternity ultrasound is reviewed to enable use of available private capacity for time-bound ultrasounds which releases public capacity for other ultrasound of equal priority

**Summary of recommendations 7.9 Radiology**

- Establish a single Radiology Clinical Network
- Ensure consistency in the development of national clinical pathways involving radiology including for cancer surveillance
- Data are collected and reported nationally on CT, MRI and other outpatient radiology modalities that includes the number of patients on any radiology waiting list nationally by district, ethnicity, priority and waiting time bands
- Public Radiology services should apply the nationally agreed prioritisation criteria endorsed by National Radiology Advisory Group
- Each region must establish consistency of approach to radiology waiting list management as an immediate priority
- There should be regional cooperation to share access if clinical risk in one district for a modality is excessive compared to reasonable alternative access within the region. This may include amending which districts access a private provider
- Regions should have support services established especially to assist Māori and Pacific patients access imaging. This is an immediate priority
- The level of additional private sector capacity required to recover waiting lists regionally needs to be determined
- A nationally consistent approach to pricing, volumes and term of agreements negotiations is developed and put in place
- Regional stocktakes of private sector capacity to support equitable recovery for all populations should be developed
- Te Whatu Ora considers mobile diagnostic opportunities as an immediate priority. Mobile facilities offer considerable advantages for improved access and timeliness
- Review the Section 88 ultrasound payment.

- National guidance is established to ensure publicly funded ultrasounds are limited to those that are clinically indicated to support safe maternal and foetal care.

## 7.10 First Specialist Assessment – opportunities for change



### Interventions: prioritisation and management of referrals for FSA

Clinical risk exists at various points on the FSA waiting list. Most high priority cases are being seen within broadly acceptable clinical timeframes. However, risk also exists for patients experiencing excessively long waiting times for FSA. It is therefore vital to address both groups. The Planned Care Directive from Te Whatu Ora outlines the necessary work to schedule out-patient review of those patients waiting excessively long. The Taskforce also notes the equity requirements of the Directive.

Recommendations regarding the approach to waiting list management and scheduling processes is given in section 7.13, below.

As the excessively long waiting lists are being addressed, work is also required to embed better processes and systems and to value the skills of other professional groups. Consistency of acceptance criteria and the grading of referrals is essential for equitable access to health care. It is imperative that each region works toward nationally consistent access thresholds for specialist review.

#### The Taskforce recommends:

- Immediate priority be given to work towards developing consistency in acceptance criteria and grading of referrals nationally
- Incorporating a risk-based assessment of cohorts, take actions to address priority 1 and 2 cohorts of patients that are waiting longer than clinically acceptable for first specialist assessment
- Review waiting lists regularly
- Identify the patients waiting >12 months for FSA using the clinically assigned priority and book FSA in priority order, noting the equity requirements of the Directive.

The Taskforce notes work underway to determine relevant adjustments for equity at the time of receipt of a referral therefore adjustments to processes are anticipated.

To achieve sustainable, equitable, and improved access alternative approaches and new tools need to be developed that either reduce the need for an FSA or improve timeliness to an FSA.

To further improve access, the Taskforce supports the development and expansion of clinical guidance and pathways to allow more seamless and logical progression of patients through the continuum of planned care.

**The Taskforce recommends a number of generic measures to improve knowledge of demand and performance:**

- To determine the level of variation across districts and specialties there is a requirement to record the rates of referrals received vs declined or accepted by district and specialty
- To enable measurement of planned care performance all regions must be reporting accurate National Patient Flow (NPF) data that reflects activity
- Establishment of measures to assess unmet need including referral rates from primary care to specialist services.

There are opportunities to better utilise the skills and expertise of various clinicians for what are collectively referred to as first specialist assessments. For example, Nurse Practitioners and Clinical Nurse Specialists currently deliver services that aid the management of many conditions in many districts. As an alternative to requiring secondary specialist medical review, advice and management, there are opportunities to further develop integration between primary and secondary services with some management coordinated and/or provided via Nurse Practitioners and/or Clinical Nurse Specialists. Such opportunities should be developed and enhanced. These may be of particular benefit for the management of chronic out-patient conditions. Flow into these services should be possible via direct referral from primary care or after secondary service review or treatment.

- There are significant potential benefits to timeliness and flow if primary care is able to refer directly to allied health for assessment and appropriate management of some conditions and the Taskforce recommends a number of opportunities be considered. The Taskforce recommends that Te Whatu Ora seeks specific expert advice on these opportunities which include:

**7.10.1 Allied Health Assessment of Musculoskeletal conditions**

At present, the waiting times for both assessment and surgery for many musculoskeletal patients are excessive. Assessment relies on a surgical FSA. Inconsistent use is made of non-operative options for symptom management or alternatives to specialist review.

Evidence exists that assessment by a MSK physiotherapist for some patients with various orthopaedic conditions has benefits by providing assessment and non-operative management. This improves timeliness to assessment, and for some patients, symptomatic benefit which may delay or ameliorate the need for surgery.

Multiple benefits have been identified in the Bay of Plenty experience including reduced numbers of patients requiring surgery and improved uptake of the opportunity by some patient groups for clinical review. The Taskforce notes similar programmes have begun in multiple locations

- Based on the Bay of Plenty experience, a proposal has been developed by the national Directors of Allied Health
- The Taskforce notes that ideally, primary care will be able to directly refer appropriate patients to this programme, but again the Taskforce notes some patients may benefit from direct referral for a surgical FSA
- The cost identified for implementing the first phase of the proposed approach, which includes physiotherapist wait-list review for all current orthopaedic patients waiting for FSA over 4 months is \$2.9M.



In addition to utilising the BOP approach, the Taskforce is aware of some districts utilising orthopaedic physiotherapy expertise to perform assessments of back pain. The success and applicability of this work should be assessed.

**The Taskforce Recommends:**

- In the immediate phase, the Taskforce supports implementation of a nationally consistent care pathway that incorporates allied health professionals to ensure timely, evidence-based interventions before and/or instead of orthopaedic surgery, noting the Taskforce's support for rollout to all patients is contingent on establishing clarity of the benefits to Māori and Pacific patients, including access to the pathway or if more appropriate, access directly to orthopaedic review all within equitable timeframes
- The role of orthopaedic physiotherapy in assessment should be considered as national programme. Collaboration between physiotherapists, orthopaedic specialists, and the Physiotherapy Board is necessary.

**7.10.2 Role of Audiology in improving access**

On acceptance of FSA requests, most Otorhinolaryngology services schedule these patients to be seen in a specialist clinic. However, given the nature of some ORL conditions there are opportunities to increase utilisation of audiologist skills and at the same time better utilise ORL surgeon resources. The Taskforce notes some programmes exist where:

- Audiology assessment of children referred with serous or recurrent otitis media and similar hearing concerns occurs prior to any specialist review. A programme in one district has been shown to reduce the time to first assessment by 50%, and to improve time to first specialist assessment and treatment (in this example, grommet insertion) for those still requiring surgery.
- For those children seen by an audiologist, approximately 50% were discharged without needing surgical intervention, and most without the requirement for review by a senior medical officer prior to discharge.
- FSA to waiting list conversion by the surgeon is higher if cases are triaged via audiology with the surgeon booking 82% of children referred by the audiologist for surgical consideration compared with only 57% in the group of children seen directly by a surgeon.
- Overseas experience also shows value in allied health workforces to provide initial clinical assessment and early treatment for the following groups of people:
  - Audiologists for children's otitis media and hearing screening
  - Speech Language Therapists for dysphagia and dysphonia
  - Physiotherapy for vestibular dysfunction.

**The Taskforce recommends:**

- That work is commissioned with expert groups to develop and agree implementable national pathways for the use of allied health workforces to provide initial clinical assessment and early treatment following triage of specified cohorts of ORL referrals.

**7.10.3 Increasing Ophthalmic capacity**

An ageing population means that more people are developing chronic eye conditions. There is an increase in prevalence of age-related macular degeneration (AMD), diabetic retinopathy (DR) and glaucoma, all of which are potentially blinding conditions that frequently require lifelong monitoring, and often treatment, to prevent irreversible visual loss.

Ophthalmology waiting lists for FSA and procedures are large and continue to grow (3,596 waiting over four months for FSA; 3,258 waiting over four months for procedure), but even

more concerning is the large follow-up waiting list and delays for care (35,748 overdue at end of May 2022, 19.2% or 6,864 of whom have waited 50% over their due date).

Five projects were funded through planned care service improvement funding in 2020/21 and 2021/22 to develop alternative workforces in Ophthalmology FSA, Avastin injections, and follow-ups, and one project which addressed regionalisation and standardisation of the service in the Northern Region.

Workforces used to provide alternative to SMO (Senior Medical Officers) for clinics included Optometrists, Orthoptists, Ophthalmology assistants, Registered Nurses, and Nurse Practitioners. These clinics are still in progress for initial pilots, and are located in; Counties Manukau, Canterbury, Hutt Valley and Nelson Marlborough.

The Northern region Ophthalmology Regional Service improvement programme has had success in bringing together clinical leadership across the four districts within the region which has led to improving equity of access and increased consistency across a number of elements of the service. Key to the success was; shared governance, accurate and standardised data dashboards, and resourced project management support.

Most of these funded projects had start dates between November 2021 and January 2022, and the projects, and context within which they are being developed have been significantly affected by the Omicron peak. Timeline extension will be required for full benefit realisation of investment. Some anticipated district benefits are:

- Counties – anticipates 300 FSAs for failed photo-screening for diabetes retinal screening service, 1,000 patients for post-operative cataract refraction assessment, and 2,700 diabetes low-risk FSA/FU appointments per annum can be seen by non-ophthalmologists. This would allow approximately a further 4000 other patients to be seen by SMOs in clinic at Manukau Health Park.
- Hutt – anticipates 300 patients can be seen by community optometrists.
- Nelson Marlborough – employment of a Clinical Nurse Specialist and development of a Nurse Practitioner position offer considerable opportunity for improved access (noting these initiatives have been significantly delayed by Omicron)
- Canterbury - expects to outsource 120 cataracts to private before the end of the project, and offer a voucher system for patients to be seen by community Optometrists for both FSA and follow-up (volumes to be confirmed).

**The Taskforce recommends:**

- Te Whatu Ora monitors and evaluates the outcomes of the pilots that are increasing Ophthalmic capacity. Where benefit is confirmed, assess the opportunities to develop these services in other districts with emphasis on the use alternative workforce models to see ophthalmology FSA and FU patients in the community and that a development and commissioning workstream should focus on this area.
- Alongside these pilot projects, an opportunity has been identified to establish a working group to evaluate the potential for and development of pathways involving optometrists in the provision of intravitreal injections (e.g. Avastin).
- The Taskforce is aware of new therapeutic options overseas for intravitreal injection that if introduced here would significantly extend the period between injections, The Taskforce recommends this potential be raised with PHARMAC.

The above examples all bring the potential to improve access to services patients will benefit from and to free up senior medical officer time for those consultations and roles that require specialist input.

**7.10.4 Targeted review of people on the waiting-list for first specialist assessment**

- This is an immediate measure that may identify some patients for whom a first specialist assessment may no longer be required given the excessive time from acceptance of the referral. It is NOT seen as an initiative to be embedded as a routine strategy.

Three districts have piloted this approach:

- Benefits have been demonstrated from primary care review of people waiting for excessive periods (> 365 days) on specified waiting lists for first specialist assessment in one district. This has led to approximately 8-10% reduction in patients still requiring a secondary care appointment
- The Pilot involved primary care clinicians, but the Taskforce sees no reason any suitably qualified and skilled clinician could not undertake this type of work
- Consideration of this approach throughout all regions is recommended although it will likely best be effective only in some specialities and for some conditions where there is a recognised potential for resolution of symptoms due to the excessive time on the waiting list.
- The Taskforce notes that if performed outside of secondary care there will be funding requirements.

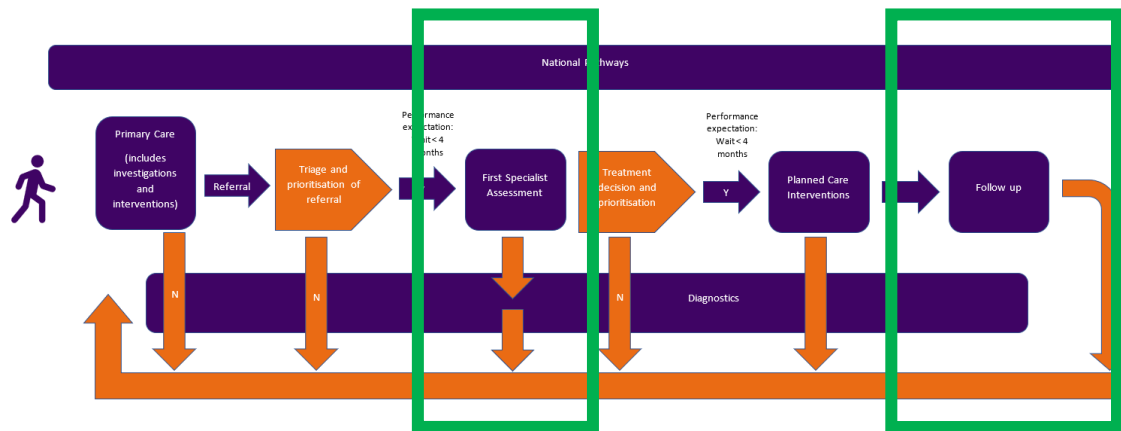
**Summary of recommendations 7.10 First Specialist Assessment – opportunities for change**

- Immediate priority be given to developing a standard approach and language to prioritisation of waitlist entries and clear definitions of maximum expectations of time spent waiting prior to provision of care
- Ensure appropriate scheduling of priority 1 and 2 cohorts of patients.
- Identify the patients waiting >12 months for FSA using the clinically assigned priority and book FSA in priority order
- Consider ways to enable review of whether some long-waiting patients still require FSA
- Develop a regional and then national approaches to recording and understanding the rates of referrals received vs declined
- Embark on programme of work towards full compliance with National Patient Flow (NPF) data requirements
- Establishment of measures to assess unmet need including referral rates from primary care to specialist services
- Implementation of a nationally consistent care pathway that incorporates allied health professionals to ensure timely, evidence-based interventions before and/or instead of orthopaedic surgery, within equitable timeframes
- That work is commissioned to develop and agree national pathways for the use of allied health workforces to provide initial clinical assessment and early treatment following triage of specified cohorts of ORL referrals
- Monitor and evaluate the outcomes of the pilots that are increasing Ophthalmic capacity.
- Establish a working group to evaluate the potential for and development of pathways involving optometrists in the provision of
- The Taskforce recommends the potential for new therapeutic intravitreal injections options overseas for intravitreal injection be raised with PHARMAC



## 7.11 Use of Telehealth

Telehealth consultations offer opportunity to improve access for those patients in whom a physical (in-person) consultation is not deemed necessary.



There are important equity considerations. These include:

- Cellular and internet coverage
- Interpreting services

There are geographical differences in internet and cellular coverage that disproportionately affect rural and remote communities and therefore telehealth potentially risks worsening some aspects of health inequity. In addition, economic factors impact personal access to digital devices. Opportunities exist to develop community centres for telehealth where patients can access services from their own community if they lack personal digital access. Language must be appropriate for all consultations. Where this is a barrier to telehealth patients must receive access at a similar time to an in-person consultation.

The concept of Patient Anywhere, Specialist Elsewhere (PASE) has been developed (Figure 2). The concept relies on a national booking system and shared health record and can be imagined as a cloud based, multispecialty health service provider which is not reliant on bricks and mortar

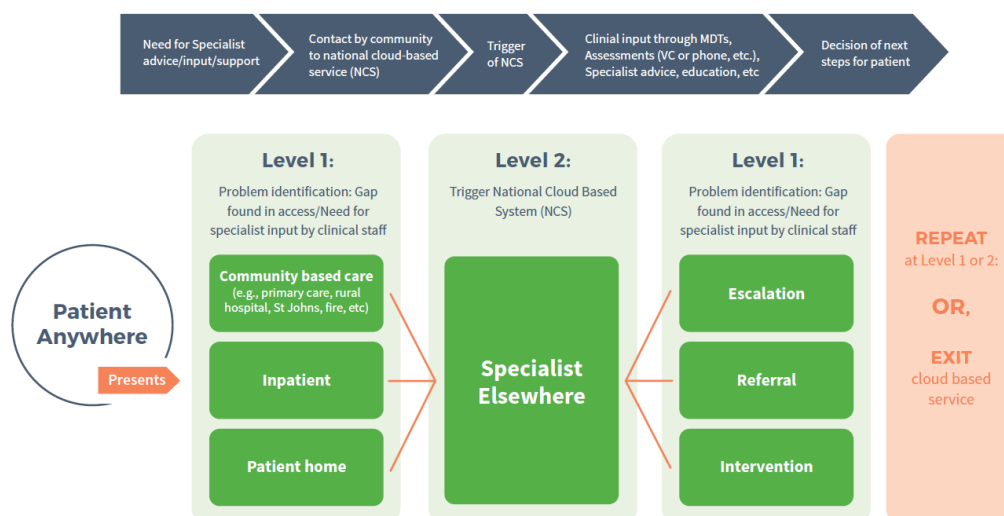


Figure 2 PASE Workflow recognising that the patient can be anywhere but receive care from a specialist elsewhere

There is national and international evidence of healthcare models similar to PASE, based on collaborative teams involving primary care clinicians, secondary care specialist doctors, nurses and allied health service professionals. Some international examples in OECD countries include the management of hypertension, stroke, dermatology, adult and paediatric emergencies, hospice care, and chronic conditions such as asthma, arthritis and congestive heart failure, involving cardiologists, neurologists, psychologists, paediatricians and radiologists. Examples of projects and pilots in New Zealand are available on the New Zealand Telehealth Forum and Resource Centre National Telehealth Register.

A review of international, national and local models from New Zealand enables an insight into some of the key benefits and challenges of such an approach. However, none of the current models take a holistic approach across whole of country. This is where the PASE model differs, offering a collaborative cloud-based approach to healthcare providing multiple benefits, both for patients and their whānau, as well as for clinicians.

One such care model spans multiple pathological processes and specialties to consider developing a National long COVID-19 telehealth model as an immediate priority. This model would allow patients anywhere to receive multi-disciplinary. Given the impact of this disease and the need for timely support for sufferers, a service of this nature would seem an ideal national PASE model.

The Taskforce recommends that further evaluation, development and implementation of models occurs to improve access especially where services are vulnerable or based on a small number of specialist staff or networks of capability.

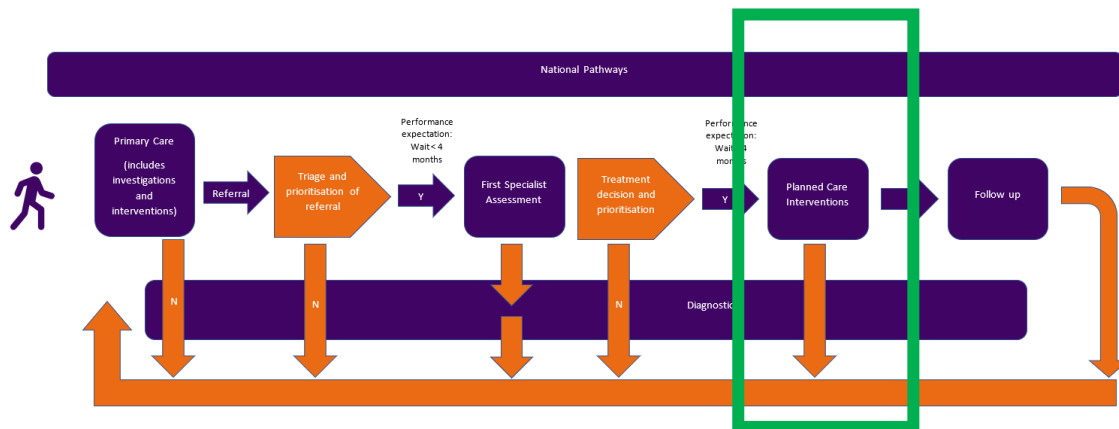
At the same time, Districts and Regions should continue to develop telehealth to reduce the reliance for some patients having to travel to clinics where no material benefit is derived from an in-person consultation. Such development should include whether telehealth capability can be provided in a community setting to assist those without digital access.

### **Summary of recommendations: 7.11 Use of Telehealth**

- Further evaluation, development and implementation of models occurs to improve equity especially where services are vulnerable or based on a small number of specialist staff or networks of capability
- Districts and Regions should continue to develop telehealth to reduce the reliance for some patients having to travel to clinics where no material benefit is derived from an in-person consultation. Such development should include whether telehealth capability can be provided in a community setting to assist those without digital access
- Te Whatu Ora works with Te Aka Whai Ora on developing access to telehealth services especially in rural communities
- Te Whatu Ora works with other government agencies to address cellular and internet coverage issues

## 7.12 Interventions: Treatment (ESPI 5)

There is the immediate challenge of the existing waiting lists and the need to review aspects of the in-flow of new cases



The planned care Directive from Te Whatu Ora outlines the necessity of scheduling those patients waiting excessively long (>365 days). It is important to note the approach to improving equity in the excessively long waiting group.

### The Taskforce Recommends immediate actions:

- Services review their waiting lists to ensure as far as possible that cases do not need a new clinic assessment
- Cooperative work within regions to address gross inequities of access especially for high priority cases

Regional consistency of processes to support planning and delivery including a regional view of demand and capacity to support prioritisation of capacity to improve equitable access within a region. In the immediate period, the Taskforce recognises the considerable impacts of winter illness, the pandemic and staffing on the ability of all providers to work to maximum capacity. However, opportunities exist to both refocus how treatment is delivered and to expand some access without a significant impact on staffing through improved use of resourced capacity.

The issue of individual clinician waiting lists versus “pooled” lists is complex, but there is a need to avoid unjustified differences in time to treatment simply because one surgeon has a significantly longer “waiting list” for surgery than another for patients with similar conditions and clinical priorities.

### The Taskforce Recommends:

- As per the planned care Directive from Te Whatu Ora, scheduling must address those patients waiting over 365 days with priority within this group to Māori and Pacific
- At the same time, treating P1 and P2 in the right timeframes.
- Pooling of lists for certain conditions and procedures as an immediate opportunity.
- If volumes are being outsourced, the case selection must be across the totality of the waiting list and must explicitly address excessive waiting times. It cannot be left to individual clinicians to choose from their “own” lists
- Where a case is not suitable for outsourcing, treatment must not be further delayed in Public facilities compared to similar priority cases (who have experienced the same delay) which are suitable for out-sourcing

Greater clarity and transparency about excessive long-waiting cases is required as well as clear plans for the management of these cases.

**The Taskforce recommends:**

- Waiting times need to be accurately measured and reported both at District and Regional levels and assessed nationally by Te Whatu Ora.

**7.12.1 7.4.1 Prehabilitation**

There is increasing local and international interest and evidence to suggest some patients may obtain significant clinical benefit from targeted interventions prior to planned care surgery. This is referred to as prehabilitation. Benefits shown in some patient groups include a reduction in peri-operative complications and a reduced length of stay. The Taskforce is aware one district has a form of this programme already in place.

**The Taskforce recommends**

- That expert review of the concept of prehabilitation is conducted noting, however, that applicability may not be able to be fully determined without prospective research.

**7.12.2 Tertiary and National Services**

Various services currently provide what are collectively referred to as “tertiary services”. There are a smaller number that are truly national.

There is a need to review how these function and the results achieved to ensure best practice and outcomes are achieved.

There is also a need to ensure proper resourcing of these services to meet especially acute needs to reduce the impact of these demands on planned care delivery.

The Taskforce notes existing work on some tertiary and national services occurs via the National Tertiary and Quaternary expert group.

**7.12.3 Provision of specialist dental care**

Provision of specialist dental care, especially that which requires sedation or general anaesthetic is an area that requires special attention as current capacity in the paediatric oral health service is inadequate to keep up with the demand and this is adversely affecting Māori and Pacific.

In June 2022, 2,173 of 2,564 patients waiting more than 4 months for dental surgery (85%) are under the age of 19, and almost half of the total overdue waiting list are aged between five and nine years (1,164). Unmet dental need is as yet unknown. The Taskforce notes there is an immediate need for improved data regarding dental waiting lists to allow for improved service planning and delivery. The Taskforce notes that there is no visibility of the number of patients waiting for outpatient dental assessment as this information is not included in routine ESPI 2 reporting. The Taskforce is aware that in some districts there are significant numbers of patients waiting for more than 12 months for outpatient assessment and many of these are children.

Some Planned Care Service Improvement Projects have been focussed on improving outcomes in this area. Generally, these have included:

- Locality based operating rooms are being identified to ensure better access closer to home including use of the mobile surgical unit
- Use of Māori and Pacific care navigator teams to support whānau attending appointments

- Implementation of weekend clinics or changes to clinic times based on attendance data
- Inclusion of a clinical pathway from primary care to hospital dental services for Māori offering a community-based sedation service at the community kaupapa Māori dental service
- Adding to capacity through the use of additional community-based specialist clinics treating patients under sedation rather than general anaesthetic to release operating theatre capacity for cases that can only be provided in that setting
- The Taskforce notes an opportunity and need to consider enhancement of mobile facilities

**The Taskforce recommends**

- A commissioning workstream be put in place to agree and implement new national and regional pathways and commission increased capacity for specialist dental treatment.
- Action is taken immediately to establish the number of people waiting for outpatient assessment by waiting time bands and implements a routine requirement for the reporting of this information on a monthly basis
- Te Whatu Ora establishes expectations regarding maximum waiting time for dental assessment and treatment and actions specific to the improvement of waiting times for outpatient dental assessment and specialist dental treatment are established within each district delivering these services

**Summary of recommendations 7.12 Interventions: Treatment (ESPI 5)**

- Scheduling must address those patients waiting > 365 days with priority within this group to Māori and Pacific
- Treat P1 and P2 in the right timeframes.
- Work to occur to identify actions to address observed inequities based on ethnicity on waiting lists including shared use of available regional capacity
- Consider pooling of lists for certain conditions and procedures
- If volumes are being outsourced, the case selection must be across the totality of the waiting list and must explicitly address excessive waiting times.
- Waiting times need to be accurately measured and reported both at District and Regional level and assessed nationally by Te Whatu Ora
- Identify actions to address observed inequities based on ethnicity on district waiting lists including shared use of available regional capacity
- Institute regional wait lists with regional clinical leadership to assess consistency in how patients are assessed and referred to wait lists
- Where practical and capacity exists, patients will be offered opportunities to get their surgical planned care outside district.
- Facilitate the movement of teams between sites to make the most of underutilised capacity and improve access
- That expert review of the concept of prehabilitation is conducted
- A commissioning workstream to agree and implement new national and regional pathways to increase capacity for specialist dental assessment and treatment
- Action taken to establish clarity of the dental waiting list
- Maximum waiting times for dental treatment be introduced and monitored

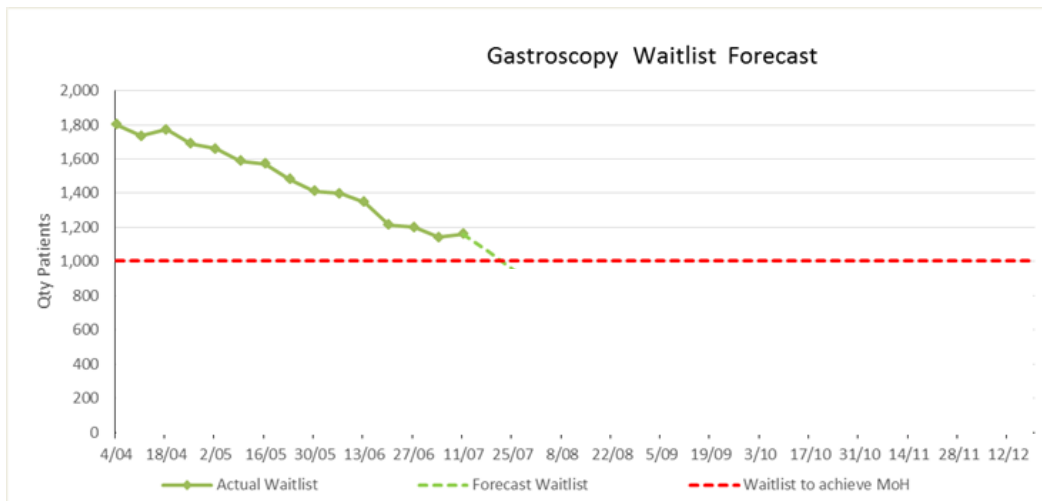
## 7.13 Intervention - Consistency in processes including resource utilisation and scheduling

### 7.13.1 The requirement for waiting list management to be active

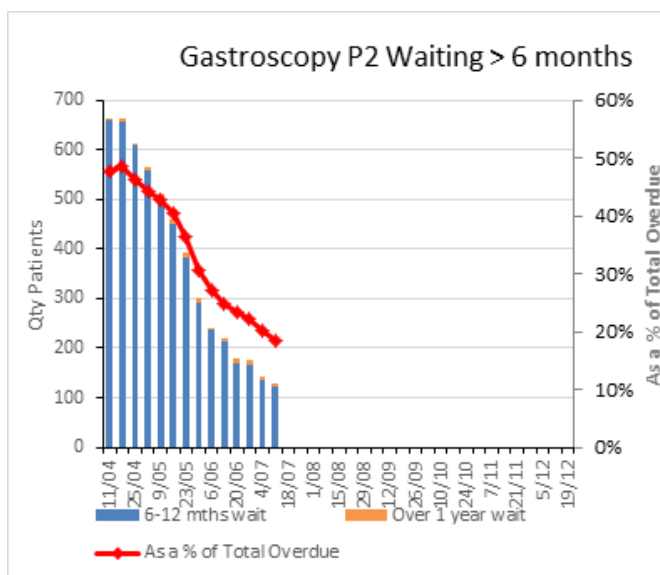
Active and focussed management of waitlists is required for true, sustained progress to be made. This must have the commitment of senior managers and direct involvement and support of clinical leaders. This is required for all waiting lists including FSA, follow-up, Diagnostics and Treatment waiting lists.

For example, active and focused management of the gastroscopy waiting list (see graphics below) has led to the following improvement in one district, noting that “sustainable” attainment of the waiting times target of all cases performed within 90 days of entering the waiting is achieved at or below a total waiting list of 1,000 patients at any one time in this service.

Taking a disciplined, production planning informed, approach to the selection and management of work to be done will be successful, as indicated in the following graph, showing the total waitlist:



This reduction is matched by a total reduction in those patients waiting more than 6 months:





In another example of attention to detail an Audiology department has demonstrated that being more logical in its management of how staff are used has enabled it to:

- Reduce the total number of adult patients referred with hearing concerns on its waiting list from 371 in January 2022 to 276 in July 2022
- Median waiting days of patients on the list has reduced from 203 to 141
- Patients overdue decreased from 175 (47%) to nine (3%)
- The department is looking at a range of other improvements it can make through focussed plan-do-study-act cycles.

### **7.13.2 Public Hospital Operating Room capacity**

The Ministry of Health commissioned Ernst Young (EY) to undertake an assessment of operating room (theatre) utilisation across each (former) DHB in the 2018/19 financial year period. Substantial reports were subsequently made available to each DHB. While accepting there may have been some improvements in the period since, any subsequent refresh of this analysis is likely to be distorted by the impact of COVID-19 demand on operating room (OR) utilisation and is therefore not likely to be reliable. The findings of the EY review in respect of OR utilisation can be summarised in the following way:

- A view of efficiency was established based on an assumption that the operating room team used the scheduled (resourced) list duration fully without over-runs or cancellations. A measure of median efficiency was developed based on a composite of session utilisation and planned cases completed. The median efficiency identified nationally was 57% with a range of 31.1% to 72%.
- Early finishes to operating room sessions occurred commonly across all districts and 20% of early finishes ended more than one hour earlier than the resourced sessions allowed.

These findings suggest there is opportunity to deliver more surgery within currently resourced and scheduled operating room sessions. According to the EY survey in 2018/19 there are 243 operating rooms available within Health New Zealand public hospital facilities.

There is an immediate need to update and clarify these data, however, if we assume 65% of these operating rooms are resourced to deliver elective services only (35% available for acute activity only) and if each elective OR delivered two more procedures per week (over 45 weeks per annum) this would equate to 14,215 additional elective procedures delivered in public each year. Noting the upper range of median efficiency nationally was 72% it is possible that an additional three procedures per week is achievable and this would equate to 21,323 additional procedures each year delivered in public hospitals.

It appears almost certain that improvements can be achieved in both productivity and efficiency through changes in:

- On time starts
- Full utilisation of lists
- Effective processes to smooth the turnaround of theatres between cases, readiness of patients and clinical teams for prompt starts
- Agility in allocation of theatre capacity based on measures of priority of specific cases or, more generally, population requirements
- Clarification of total length of all planned care operative sessions – this should include work to determine if an extension to the traditional duration of theatre times is safe and practical in each district
- Development of sustainable in-sourcing models.



There are existing measures of such characteristics that are visible within hospitals, however it is likely that the definition of measures and targets differs between hospitals. It is acknowledged that the Health Roundtable reports some measures of theatre utilisation, however there is not a measure of characteristics of theatre utilisation, efficiency or productivity that is clearly visible and allows comparison of performance at a district, regional and national level.

**The Taskforce recommends that in the immediate term:**

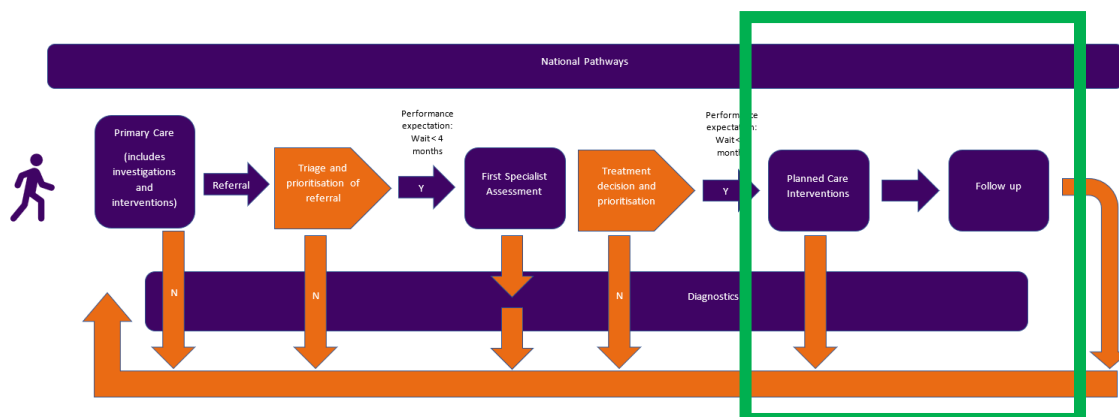
- Action is taken to confirm the number of resourced operating rooms available (noting the EY work may be outdated) and confirms the proportion of these that are dedicated to elective service delivery only
- Work is undertaken to establish key metrics to support weekly monitoring and reporting of operating room utilisation at a district and regional level
- Consideration is given to establishing a volume target expectation at a district level of increased internal delivery of planned care surgery within existing resources.

**Summary of recommendations 7.13 Intervention - Consistency in processes including resource utilisation and scheduling**

- Te Whatu Ora establishes an expert working group to establish a national set of agreed metrics such as the definitions of theatre start time and theatre utilisation
- Transparent reporting of theatre utilisation, efficiency and productivity
- Improve overall theatre capacity and utilisation within the public system
- Confirm the number of resourced operating rooms available and the proportion of these that are dedicated to elective service delivery only
- Establish key metrics to support weekly monitoring and reporting of operating room utilisation at a district and regional level
- Consideration is given to establishing a volume target expectation at a district level of increased internal delivery of planned care surgery within existing resources
- Booking and scheduling needs to be properly resourced and rigorously monitored to ensure correct waiting list management.

## 7.14 Follow-ups

There is a significant need and opportunity to create capacity in out-patients. This potentially improves timeliness for both new patients and follow-up patients who require a clinical review.



Creating capacity is essential to reduce clinical risk on the out-patient waiting lists (both FSA and follow-up).

Many follow-ups are clinically appropriate especially in relation to conditions where secondary or tertiary review and management is necessary to maintain current health and prevent further deterioration especially in chronic conditions. However, there are significant opportunities to improve access and consistency especially through further development of relevant clinical pathways and guidelines. This work will require expert working groups in and between specialities and subspecialties. Focus should be given to the question of why secondary review is necessary. There is also a need to define where there are clinically acceptable benefits from developing better integration with primary care.

As with any other planned care waiting list there will be increasing clinical risk on follow-up lists for some patients, especially those where active secondary decision-making is required to maintain the current health status of the patient. These cases need prioritisation within follow-up planning.

The Taskforce believes there is considerable opportunity to remove unnecessary or poorly timed appointments from the system, thus creating capacity, particularly in support of increased delivery of, and timely, access to FSA.

Clinical consistency is essential to avoiding strategies that waste time and inappropriately use resource. This should include clarity as to which clinician can perform the follow-up – for example specialist nursing, allied health or medical.

Clinicians must ask what value the patient would gain from a follow-up appointment. If an appointment is still required, the question of mode of delivery should be considered: Is an in-person appointment required?

A reduction of 10% in total follow-up appointments scheduled over 12 months will generate approximately 125,000 vacancies. These should be used to address the FSA backlog and anticipated growth as well as allowing better access for those overdue follow-ups where clinical risk is increasing due to deterioration in access.

Further work is needed to identify the opportunities to implement proven alternative models including nationally consistent pathways to quantify the potential capacity (workforce and facility) able to be released to support other planned care, including first specialist assessment and treatment services.

### **Summary of recommendations 7.14 Follow-ups**

#### Immediate Steps:

- Create significant capacity for FSAs by eliminating unnecessary follow-ups. Facilitate discussions with services to identify lower value follow up work that can be avoided to enable provision of long wait FSA and treatment
- Review of follow-up plans at discharge – i.e., do not leave this decision to RMOs alone
- Review of current follow-up lists, especially to identify patients where clinical risk is regarded as excessive
- Consideration of the value of further follow-up each time a patient is seen in clinic – oversight of this should be provided by SMOs
- Explore the role of patient-initiated follow-up after some procedures (i.e., only to be seen if issues remain as opposed to routinely seen in clinic)
- Consider expansion of virtual advice as appropriate, as distinct from telehealth appointments
- Increase the use of telehealth for follow-up work that is necessary but where in-person contact is not essential
- Overdue follow-ups data needs to be collated by region, district, ethnicity and specialty to understand the extent of the waiting list challenges.

#### Medium-term:

- Explore the role of non-hospital follow up; for example, the role of optometry in follow-up for some ocular conditions
- Further develop roles of Nurse Practitioners and Clinical Nurse Specialists and allied health colleagues.

## **7.15 Interventions: Private Sector Capacity**

In November 2020, the New Zealand Private Surgical Hospitals Association (NZPSHA) provided a capacity stocktake of their membership organisations that quantified additional capacity available to support MOH and DHB funded planned care delivery. The information provided in this capacity stocktake was reviewed by the Taskforce and funders responsible for commissioning private hospital and specialist services within regions across the country. It was found that the information was incomplete and lacked the required specificity to be able to be useful and that the capacity suggested was not actually available to DHBs at the scale and timeframes suggested.

Te Whatu Ora re-engaged with the NZPSHA in early June 2022 to support the work of the Taskforce and requested an updated stocktake with a more explicit level of detail to enable an assessment of the available capacity to support planned care recovery nationally from 2022/23. Unfortunately, the updated information from NZPSHA received in late July 2022 does not contain some detail necessary to allow the Taskforce to complete a reliable assessment

of available capacity. It should be noted that while NZPSHA represents approximately 60% of private hospital providers and many inpatient surgical providers, their membership does not include many day patient surgical providers and endoscopy and radiology service providers.

Hospital and specialist services funders have been working together nationally to support the work of the Taskforce to establish a view of private sector capacity available per region, but progress has been slow to date in most regions.

Based on what is known by funders at a regional level currently:

- There is limited marginal capacity for inpatient elective planned care within all regions and some districts within regions have very few or no options to access private capacity locally to meet the wait list needs
- Not all districts have existing contracts in place to take up any marginal capacity that may be available to support inpatient elective planned care delivery
- There is available capacity in all regions - but not in all districts - for additional day-patient services and to a lesser degree for diagnostic services
- Private providers in some regions are unable or unwilling to renew or enter into new fixed volume commitments for the short or medium term
- There are few private providers willing to continue to provide services they have been delivering over time at historic prices and in many instances, there are requests for significant uplifts to historic prices – in some cases up to and in excess of 20%
- There is wide variation in prices across contract agreements at a district and regional level for the same procedures (diagnostic and treatment services)
- Price uplifts are being requested while volume commitments are proving difficult to establish
- Some private providers are signalling they have the ability to undertake new investments to support Te Whatu Ora's planned care service delivery, but require longer term agreements to establish this capacity.

Te Whatu Ora and the Taskforce previously recommended to Regional Directors that each region designate a single person to coordinate and align private sector capacity agreements to enable the use of available private sector capacity from 1 July 2022 on an ongoing basis to support planned care delivery. Work is ongoing within each region to establish regional processes to facilitate the immediate and ongoing use of private sector capacity.

It should be noted that at any district level and particularly in districts with less private and public sector scale, any increase in use of private sector capacity may lead to a reduction in public workforce availability to deliver existing and additional levels of planned care within the public system. This needs to be taken into account when establishing volume agreements with the private sector in the short, medium and longer term. A number of public sector leaders have raised concerns about the consequences on public capacity of additional agreements being entered into with private providers over any length of term.

The Taskforce has been approached by the NZ Orthopaedic Association who have advised there are approximately 200 orthopaedic surgeons who are willing to proactively add a public patient to existing private surgical operating lists each month for 10 months which would enable 2,000 additional orthopaedic procedures to be completed in one year. This approach would not have an unintended consequence on public workforce. Patients on the Orthopaedic waiting list are waiting longer than patients on any other waiting list and this capacity would reduce the waiting time on this list over time by approximately six weeks.

**The Taskforce recommends**

- Private sector engagement in the immediate term is coordinated regionally with the intention of securing available marginal capacity for 2022/23, supporting the prioritisation of regional private sector capacity to achieve improvements in regional equity across waiting lists, and to improve alignment across existing agreements including prices at a regional level
- Te Whatu Ora Commissioning leads a process nationally to develop a longer-term strategy regarding the use of private sector capacity to support Te Whatu Ora funded planned care in the medium and longer term, including progressing the development of a national price book and service specifications
- Length of contracting is reviewed to identify mutual advantages of greater certainty of work
- Te Whatu Ora commissioning evaluates the opportunity identified by the New Zealand Orthopaedic Association (NZOA) further and establishes a process to implementation if supported.

**Summary of recommendations 7.15 Engagement with Private Sector**

- Engage with the private sector to secure marginal capacity
- Develop a strategic commissioning framework for private planned care provision
- Specifically explore the NZOA proposal and consider implementation.

## 7.16 New Technology

The pace of technological developments in health care is considerable. There is a need for nationally consistent processes to review and advise Te Whatu Ora on the introduction of new techniques and technology.

**Summary of recommendations 7.16 New Technology**

- Te Whatu Ora establishes a process to review applications of new technology and treatments for publicly funded care.

## 7.17 Interventions: Information Frameworks

Accurate and informative data are essential in order to inform national, regional and local decision making and ensure that consistent and equitable outcomes are achieved.

Significant work is required to align definitions, ensure data are available and presented in a way that enables effective decision making regionally and nationally.

Clinicians need to give advice and options as part of “informed choice”. Appropriate data needs to support clinicians and patients. Outcome data must be informative and allow common questions relevant to patients to be answered.



Some specialty groups have effective databases. Ideally these should also feed into a national outcomes framework. The Health Quality and Safety Commission also has a significant role in this area.

The Taskforce recommends Te Whatu Ora further promotes the development of clinically relevant national outcome datasets. It is acknowledged this is likely a long-term project requiring clinical and digital input.

For the management of planned care it is essential that clinical leaders and managers at service, district, regional and national levels regularly review updated information about planned care parameters in order to make operational and longer term decisions.

Outcomes data are important in determining both investment and dis-investment. We cannot justify support for interventions where the desired benefit does not exist.

## Summary of recommendations 7.17 Interventions: Information Frameworks

- Develop, run and evaluate district and service level reports of long waits (FSA and Treatment) and promote regional approaches to remedy
- Develop a clear set of shared measures and reporting framework which displays normalised equity performance measures
- Establish ongoing weekly, monthly, quarterly reporting covering at least volume of planned care provision, number of overdue cases by time cohorts on waiting lists for planned care (including diagnostics, FSA, treatment follow up) by specialty, ethnicity and district.

## 7.18 Facilities

Facilities need to be fit for purpose. However, changing models of care and methods of delivery must also be considered.

- Mobile diagnostic and treatment services offer considerable opportunity to improve access and timeliness
- Where possible in secondary services, separation of planned care resources from acute care resources offers greater opportunity for “uninterrupted” service delivery. The Taskforce acknowledges there are “economy of scale” factors that will need to be assessed in this regard

## Summary of recommendations 7.18 Facilities

- Consider expansion of mobile diagnostic facilities
  - Consider further development of “ring-fenced” planned care facilities
  - Improve access to telehealth via facility development
- Facilities to allow patients to access telehealth may assist delivery of various aspects of planned care.



## 8 Key Measures

The Government Policy Statement on Health contains a suite of measures that will be reported. Those most applicable to planned care include those relating to:

- Equity
- Te Tiriti obligations
- Unmet Need
- Immunisation (especially as it relates to access)
- Achieving maximum waiting time requirements
- Workforce
- Financial performance (noting quality as a factor)
- Access including via digital methods.

These are reflected in the table below.

In addition to the Government’s mandated measures the Taskforce recommends a number of principles to reporting to enable the planned care system to be managed and monitored:

- Regular progress on the systematic reduction of excessive waiting times
- Prioritisation within this work for Māori and Pacific people
- Regular reporting of how districts are cooperating to achieve equitable access across various waiting lists
- Reporting should demonstrate those overseeing and managing waiting lists are doing so to address clinical priority, excessive waiting and inequities
- Description of progress on new models of care.

Measure	Expectation
Proportion of medical appointments completed through digital channels (initially outpatients and expanding to include general practitioner appointments when data is available)	<p>This measure will initially focus on outpatient services – first specialist assessment (FSA) and follow ups</p> <p>Establish a baseline for the FSAs and follow ups in year one</p> <p>The baseline will inform an expectation for year two</p>
Proportion of patients who were prioritised using approved nationally recognised processes or tools	100% of patients were prioritised using approved nationally recognised processes or tools
Proportion of people reporting unmet need for primary health care, reported by ethnicity and geographic area	<p>A decrease from the 12 months to 30 June 2019 (baseline)</p> <p>Note: As part of the New Zealand Health Survey programme, this measure is due to be replaced in 2023 and the iGPS measure definition will be revised</p>
Proportion of people waiting to receive planned specialist care who receive it within	No patients waiting for an FSA wait longer than four months

four months reported by ethnicity, specialty, and geographical area	No patients are given a commitment to treatment and are not treated within four months
Variation in the rates of access to first specialist assessment, surgery, gender affirming care and colonoscopy reported by ethnicity, geographic area and other characteristics	<p>Initially, this will reflect the Standardised Intervention Rates for inpatient planned care interventions which are to be developed</p> <p>Establish a baseline for inpatient planned care interventions delivery rate in year one</p> <p>The baseline will inform an expectation for year two</p> <p>Establish a baseline for first specialist assessment delivery in year one.</p> <p>The baseline will inform an expectation for year two</p> <p>Establish a baseline for colonoscopy delivery in year one</p> <p>The baseline will inform an expectation for year two</p>
Variation in clinical prioritisation for cancer treatment and elective surgery, reported by ethnicity, tumour stream and geographic area	100% of patients were prioritised using approved nationally recognised processes or tools
Missed appointments for specialist care, reported by ethnicity, specialty and geographic area	A decrease from the 12 months to 30 June 2022 (baseline) and the equity gap between Māori and Pacific peoples and non-Māori, non-Pacific peoples also reduces

## Appendix A. Summary of recommendations

This table provides a list of the Taskforce’s core recommendations made in the body of the document.

The Taskforce recommends that implementation is centrally monitored with regular reporting to evaluate and manage progress.

Te Whatu Ora will determine responsible directorates and timelines as it develops the implementation plan.

To aid Te Whatu Ora with prioritisation of the recommendations if a “stratification” was required, we have indicated in **green** the measures the Taskforce believes are those which should be prioritised first. There are natural overlaps in recommendations as some are relevant across various aspects of the continuum and we have been consistent in repeating these.

What is to be done
<b>RR Plan 1.</b> Examination of data to determine the extent to which interruption to planned care has disproportionately affected Māori
<b>RR Plan 2.</b> Confirm an explicit prioritisation framework if delay/cessation of any services are required
<b>RR Plan 3.</b> Confirm an explicit prioritisation framework for restarting services that have been deferred
<b>RR Plan 4.</b> Services should reorient to meet the needs of Māori including interventions such as redeploying existing staff or using alternative locations to deliver services
<b>RR Plan 5.</b> Monitor, report and act upon impacts on equity for Māori from the pandemic, and specifically outline how Te Tiriti obligations will be met throughout the planned care reset and restart
<b>RR Plan 6.</b> Report reduction of excessive waiting times of Pacific
<b>RR Plan 7.</b> Ensure ethnicity information is accurately collected and presented in accordance with HISO standards
<b>RR Plan 8.</b> Establish expert working groups to achieve national consistency in relation to access policies based on BMI, HbA1c and smoking status
<b>RR Plan 9.</b> Develop nationally consistent policies regarding “did not attend”. These policies should include the role of cultural support/culturally appropriate health navigation services.
<b>RR Plan 10.</b> Development of Pacific equity, community and family focussed models for care navigation should be investigated (community out into hospitals)
<b>RR Plan 11.</b> Ensure visibility of data and evidence that specifically identifies where inequity exists in the pathway for Pacific
<b>RR Plan 12.</b> Long term investment in Pacific workforce
Current State Analysis – Planned Care Overview
<b>RR Plan 13.</b> Te Whatu Ora to review existing data analytics capability and capacity and consider the data governance and data quality processes required to enable robust measurement and monitoring of planned care service delivery
<b>RR Plan 14.</b> Review the ongoing requirements for national data governance and data quality management systems to provide assurance of the quality and completeness of national collections data
<b>RR Plan 15.</b> Review planned care performance monitoring frameworks and updates to include routine reporting of metrics by ethnicity
<b>RR Plan 16.</b> Establish a mechanism that provides visibility of compliance with national collections requirements, and provide feedback to support continuous improvement in data quality
<b>RR Plan 17.</b> Consider setting minimum FSA delivery volumes and follow up to FSA ratios
<b>RR Plan 18.</b> Consider setting minimum virtual follow up volumes
<b>RR Plan 19.</b> Consider extending Ophthalmology overdue follow up reporting to all services
The Planned Care Continuum
<b>RR Plan 20.</b> Work with various expert groups to ensure clarity on opportunities for improved clinical pathways involving allied health or specialist nursing roles and develop pathways for implementation.
<b>RR Plan 21.</b> Align Workforce development models of care
Unmet need
<b>RR Plan 22.</b> Develop tools to assess unmet need

<b>What is to be done</b>
<b>The “Post Code Lottery”</b>
<b>RR Plan 23.</b> Ensure Nationally consistent prioritisation systems
<b>RR Plan 24.</b> Work with clinical experts to define agreed minimum access thresholds for various conditions and work toward national capacity for such access recognising this will be a long term objective
<b>RR Plan 25.</b> Acute capacity must be right sized to avoid the frequent disruption of the system’s ability to carry out planned care
<b>RR Plan 26.</b> Where scale allows, develop capacity for the provision of planned care that is protected from the impact of acute demand
<b>Improved and Expanded Clinical Guidance</b>
<b>RR Plan 27.</b> Agreed pathways and guides should be developed that cover the whole journey through the planned care continuum
<b>RR Plan 28.</b> Where nationally validated management guidelines for a condition have been developed these should be referenced as having been consulted and appropriately followed when referring to secondary services
<b>Terminology</b>
<b>RR Plan 29.</b> Establish national consistency in the terminology used for prioritisation
<b>Primary Care</b>
<b>RR Plan 30.</b> Work with various expert groups to ensure clarity of opportunities in primary care
<b>RR Plan 31.</b> Pathways and facilities that make access to diagnostic imaging easier should be prioritised in each region
<b>RR Plan 32.</b> Assess the opportunity to roll out the primary care pathway for abnormal uterine bleeding to other districts and regions
<b>RR Plan 33.</b> That approaches to the assessment of urinary incontinence and prolapse are further assessed with a view to developing a national pathway
<b>RR Plan 34.</b> Consider the opportunities provided by moving the named range of services into the community.
<b>Diagnostics – Endoscopy</b>
<b>RR Plan 35.</b> Implement the FIT for symptomatic pathway, noting the caveats regarding equity
<b>RR Plan 36.</b> Continue to seek advice regarding the use of FIT in other aspects of colonoscopy prioritisation
<b>RR Plan 37.</b> Explore provision of endoscopy by accredited endoscopists in private facilities
<b>RR Plan 38.</b> Establish plan for increasing the endoscopy workforce
<b>RR Plan 39.</b> Explore options for mobile provision of endoscopy
<b>RR Plan 40.</b> Develop a national dataset that enables identification of all patients on colonoscopy and gastroscopy waiting lists
<b>RR Plan 41.</b> Establish waiting time indicators for gastroscopy and record these in the national dataset
<b>Diagnostics – Radiology</b>
<b>RR Plan 42.</b> Establish a single Radiology Clinical Network
<b>RR Plan 43.</b> Ensure consistency in the development of national clinical pathways involving radiology
<b>RR Plan 44.</b> Ensure data are collected and reported nationally on CT, MRI and other outpatient radiology modalities
<b>RR Plan 45.</b> Radiology services should apply the nationally agreed prioritisation criteria endorsed by National Radiology Advisory Group to the waiting lists
<b>RR Plan 46.</b> Mandate each region to establish consistency of approach to radiology waiting list management
<b>RR Plan 47.</b> Ensure regional cooperation to share access if clinical risk in one district for a modality is excessive compared to reasonable alternative access within the region
<b>RR Plan 48.</b> Where high priority cases are waiting excessively long, regions should have support services established, especially to assist Māori and Pacific patients access imaging
<b>RR Plan 49.</b> Determine the private sector capacity required to recover waiting lists
<b>RR Plan 50.</b> Develop a national strategy directing future investment in mobile diagnostic provision
<b>First specialist assessment (FSA)</b>
<b>RR Plan 51.</b> Develop a standard approach to priority categories
<b>RR Plan 52.</b> Insist on a consistent and disciplined approach to scheduling
<b>RR Plan 53.</b> Identify the patients waiting >12 months for FSA using the clinically assigned priority and book FSA in priority order by 30 Sept 22. (Waiting Times Directive)
<b>RR Plan 54.</b> Consider if review of whether long waiting patients is required to determine if FSA is still required.
<b>RR Plan 55.</b> Develop approaches to recording and understanding the rates of referrals received vs declined
<b>RR Plan 56.</b> Work towards full compliance with National Patient Flow (NPF) data requirements
<b>RR Plan 57.</b> Consider the role of orthopaedic physiotherapy assessment .

What is to be done
<b>RR Plan 58.</b> Develop national pathways for allied health and ORL.
<b>RR Plan 59.</b> Monitor and evaluate the outcomes of the pilots that are increasing Ophthalmic capacity.
<b>RR Plan 60.</b> Establish a working group to evaluate the potential for and development of pathways involving optometrists in the provision of intravitreal injections
<b>RR Plan 61.</b> Work with PHARMAC on potential new ophthalmic drugs
Telehealth
<b>RR Plan 62.</b> Continue to develop telehealth. Such development should include whether telehealth capability can be provided in a community setting to assist those without digital access
<b>RR Plan 63.</b> Work with other government agencies to address cellular and internet coverage issues
Treatment (ESPI5)
<b>RR Plan 64.</b> As per the planned care Directive from Te Whatu Ora, scheduling must address those patients waiting over 365 days with priority within this group to Māori and Pacific. Actively tackle long waiting lists and schedule ESPI 5 patients waiting >12 months by 31 Aug 2022
<b>RR Plan 65.</b> Work to occur to identify actions to address observed inequities based on ethnicity on district waiting lists including shared use of available regional capacity
<b>RR Plan 66.</b> The District and Regional approach to excessive waiting times for treatment must consider pooling of lists and approach to outsourcing to avoid worsening inequity of access
<b>RR Plan 67.</b> Waiting times need to be accurately measured and reported both at District and Regional level and assessed nationally by Te Whatu Ora.
<b>RR Plan 68.</b> Institute regional wait lists with regional clinical leadership to assess consistency in how patients are assessed and referred to wait lists
<b>RR Plan 69.</b> where it is practical, patients will be offered opportunities to get their surgical planned care outside district. This already happens in some areas
<b>RR Plan 70.</b> Increase the movement of teams between sites to make the most of underutilised capacity and ensure provision of care closer to where people live
<b>RR Plan 71.</b> Following expert review, evaluate and develop a national approach to prehabilitation pathways for at least one significant surgical cohort e.g. Fit for Surgery
<b>RR Plan 72.</b> Establish a commissioning workstream to agree and implement new national and regional pathways and commission increased capacity for specialist dental care, especially that requiring sedation or general anaesthetic
<b>RR Plan 73.</b> Establish clarity of the dental waiting list
<b>RR Plan 74.</b> Maximum waiting times for dental treatment be introduced and monitored
Consistency in processes including resource utilisation and scheduling
<b>RR Plan 75.</b> Te Whatu Ora establishes an expert working group to establish a national set of agreed metrics such as the definitions of theatre start time and theatre utilisation.
<b>RR Plan 76.</b> Transparent reporting of theatre utilisation, efficiency and productivity
<b>RR Plan 77.</b> Improve overall theatre capacity and utilisation within the public system
<b>RR Plan 78.</b> Confirm the number of resourced operating rooms available and the proportion of these that are dedicated to elective service delivery only
<b>RR Plan 79.</b> Establish key metrics to support weekly monitoring and reporting of operating room utilisation at a district and regional level
<b>RR Plan 80.</b> Consideration is given to establishing a volume target expectation at a district level of increased internal delivery of planned care surgery within existing resources
<b>RR Plan 81.</b> Booking and scheduling needs to be properly resourced and rigorously monitored to ensure correct waiting list management
Follow-up
<b>RR Plan 82.</b> Create capacity for FSAs by eliminating unnecessary follow-ups. Facilitate discussions with services to identify lower value follow up work that can be avoided to enable provision of long wait FSA and treatment
<b>RR Plan 83.</b> Review of follow-up plans at discharge
<b>RR Plan 84.</b> Review of current follow-up lists, especially to identify patients where clinical risk is regarded as excessive
<b>RR Plan 85.</b> Consideration of the value of further follow-up each time a patient is seen in clinic – oversight of this should be provided by SMOs
<b>RR Plan 86.</b> Explore the role of patient-initiated follow-up after some procedures
<b>RR Plan 87.</b> Consider expansion of virtual advice as appropriate, as distinct from telehealth appointments.
<b>RR Plan 88.</b> Increase the use of telehealth for follow-up work that is necessary but where in-person contact is not essential.
<b>RR Plan 89.</b> Overdue follow-ups data needs to be collated by region, district, ethnicity and speciality to understand the size of the waiting list

<b>What is to be done</b>
<b>RR Plan 90.</b> Explore the role of non-hospital follow-up; for example, the role of optometry in follow-up for some ocular conditions
<b>RR Plan 91.</b> Further develop roles of Nurse Practitioners and Clinical Nurse Specialists
<b>Private Capacity</b>
<b>RR Plan 92.</b> Engage with Private sector to secure marginal capacity
<b>RR Plan 93.</b> Develop a strategic commissioning framework for private planned care provision
<b>RR Plan 94.</b> Specifically explore the NZOA proposal and consider implementation
<b>Adoption of New Technology</b>
<b>RR Plan 95.</b> Establish a process to review applications of new technology and treatments for publicly funded care
<b>Information Frameworks</b>
<b>RR Plan 96.</b> Develop, run and evaluate district and service level reports of long waits (FSA and Treatment) and promote regional approaches to remedy
<b>RR Plan 97.</b> Develop a clear set of shared measures and reporting framework which displays normalised equity performance measures
<b>RR Plan 98.</b> Establish ongoing weekly, monthly, quarterly reporting covering at least volume of planned care provision, number of overdue cases by time cohorts on waiting lists for planned care (including Diagnostics, FSA, Treatment follow up) by specialty, ethnicity and district.
<b>Facilities</b>
<b>RR Plan 99.</b> Expansion of mobile diagnostic facilities
<b>RR Plan 100.</b> Consider dedicated planned care theatres, especially for surgery
<b>RR Plan 101.</b> Expand Facilities for telehealth