Office of the Minister of Health

Cabinet Social Wellbeing Committee

Health System Planned Care and Care in Community Report Back Update

Proposal

1 This paper responds to Cabinet's request for report-backs on:

1.1 the ongoing work of the Planned Care Taskforce; and

1.2 the ongoing work to transition the health components of the COVID-19 Care in the Community model to a sustainable and maintained provision of care across the health and disability sector settings from December 2022.

Relation to Government priorities

2 This paper concerns the Government's response to COVID-19 and the goal that people will be able to get the planned healthcare they require as a matter of priority.

Executive Summary

3 Planned care cannot be considered in isolation of acute care capacity in the healthcare system. This is because both use many of the same resources (i.e., workforce, theatres, procedure rooms, inpatient beds, outpatient facilities).

4 As acute care demand increases, overall capacity is diverted to respond to provide that care, particularly where it is life or limb threatening. As a result, planned care waiting lists have increased significantly since February 2020. The health system has continued to maintain planned care where possible throughout disruptive periods as a result of COVID-19, high numbers of hospitalisations, and the effects of illness that affect workforces throughout the health and disability sectors. However, the number of patients waiting beyond expectation for planned care interventions continues to increase due to COVID-19, capacity and workforce constraints, and the presentation of more complex cases.

5 The Planned Care Taskforce (the Taskforce) was established to lead the response for planned care, including the requirement to identify strategies to stabilise and reduce the volume of patients waiting beyond expected timeframes. It is led by Counties Manukau Chief Medical Officer and colorectal surgeon Andrew Connolly and includes clinical leaders across hospital and primary care settings and Te Aka Whai Ora – the Māori Health Authority, as well as funding, planning and service delivery expertise.

6 The Taskforce has identified immediate actions and activities to provide focus and direction on how to mitigate further risk to patient planned care across a range of services, such as primary care, emergency departments, diagnostic services, private health care provision, first specialist assessment and follow up care requirements.

7 The Taskforce will provide a Reset and Restore Plan to Te Whatu Ora – Health New Zealand and Te Aka Whai Ora – the Māori Health Authority at the end of July 2022. The Reset and Restore Plan will include identified actions and activities referred to above, timeframes for overall planned care backlog reductions, advice on ongoing monitoring and evaluation, and an indication of effective existing initiatives.

8 Care in the Community has shown that a holistic healthcare approach can improve outcomes and help reduce health inequities. Its success to date has been achieved through technologically-connected systems at a national, regional and local level, and collaborative partnerships across our health and welfare systems. Until COVID-19 measures, including self-isolation, are not required, Care in the Community must support people and whānau to self-isolate safely. It will also need to adapt for new variants, as it did for Omicron.

9 As the systems and processes developed for COVID-19 are folded back into the wider health and disability system, Care in the Community will also transition and evolve, including integrating its 53 care coordination hubs with localities-based care. This work will bring health providers, iwi, and social agencies together to determine what is available and needed locally.

Planned Care

Background

10 COVID-19 has been hugely disruptive to hospital systems all over the world. Two years into the pandemic, global health systems are still facing significant challenges in providing essential health services. Ongoing disruptions have been reported in over 90% of countries surveyed in the third round of the World Health Organisation's (WHO) Global Pulse Survey on continuity of essential health services during the COVID-19 pandemic.

11 Planned care includes non-acute access to care, consisting of diagnostic processes such as imaging and endoscopy, first specialist assessment and treatment such as surgery. Timely access to planned care is key to supporting the health and wellbeing of those requiring specialist care and contributes to minimising the need for acute care.

12 Planned care capacity cannot be seen in isolation of acute demand and its effect on the overall capacity of the system. There is a significant overlap in resources (i.e., theatres, workforce, inpatient beds) that is deployed to manage both acute and planned care. Further, there are very few local settings in districts that separate out planned care from acute care capacity. Where there is, the workforce is deployed to acute settings as these present greatest clinical risk to patients. This is mirrored in primary and community

capacity – particularly general practice teams, which are diverted to providing acute care and deferring work that can also have a bearing on planned care (e.g., assessment for specialist referrals). A separate paper is being prepared at my request on those short and medium-term initiatives to be actioned that will mitigate and/or shift care to reduce pressure on acute services. These two sets of activities need to be seen in tandem.

13 The COVID-19 Response and Recovery Funding provided $70 million in 2022/23 to lift the levels of planned care delivery following the disruption to service delivery caused by COVID-19 [CAB-20-MIN-0219.12 refers].

14 Before 1 July 2022, the system operated based on local decision-making, complex regional/national negotiations, regional alignment of resources, and there were limited national levers to direct resources to where the greatest need existed. This is the context in which Te Whatu Ora initiated the Taskforce in April 2022 to develop this national view and identify early opportunities for managing both demand and capacity for action from 1 July 2022.

15 In May, I reported that the number of people waiting longer than four months for their first appointments with hospital specialists had doubled because of the pandemic and significant winter illnesses affecting healthcare workforces, and the number of people waiting longer than four months for treatment had more than trebled. Further, I provided an oral update on planned care on 4 July 2022.

16 It is also important to note that Te Whatu Ora's pre -1 July assessment of national capacity to form a detailed understanding of demand and production capacity is limited by poor information. There is inconsistency in how production capacity is measured and how patients are assessed and prioritised on wait lists. District planning is also often completed in isolation of regional views and there is limited clinical leadership input to how service responses are planned.

17 From 1 July, Te Whatu Ora has in place a National Director for Hospital and Specialist Care and has established interim Regional Directors for whom planned care delivery is one of five priorities. These leadership roles have the mandate of the Chief Executive as a unified system to direct activity and resources that were not in place before 30 June 2022. Regional clinical governance is also being established to ensure quality and safety of care in decision making. Te Whatu Ora is instituting a system of issuing directives to the business to set clear expectations from regions to districts.

Workforce supply also constrains planned care delivery

18 It is anticipated that planned care waiting lists will continue to increase in the short to medium term as the provision of planned care continues to be affected by the long tail of the pandemic, winter acute medical demand, and constraints on staffing. The healthcare workforce experiences the same demand in sick leave, self-isolation, and dependent care requirements as other workforces, as a result of winter illnesses and COVID-19. Education

workforce shortages or high incidence in COVID-19 cases has meant for example that those with dependent children are sometimes required at short notice to care for their children's education and isolation needs.

19 These health-related workforce challenges come on top of large annual leave balances accrued through the pandemic, and other regular leave provisions e.g., study leave, and exacerbate the chronic workforce supply constraints experienced by health systems around the world for over a decade.

20 The reformed health system enables a new, whole-system workforce strategy and plan to be developed that addresses medium-long term supply challenges and includes the education and student placement pipeline. Te Whatu Ora and Te Aka Whai Ora have established a Workforce Taskforce to provide a whole-of-system workforce view and recommend options for the removal of barriers to developing an agile, responsive, inclusive workforce that is underpinned by Te Tiriti, Pae Ora and equitable outcomes.

21 The Workforce Taskforce will provide coordinated and executive-level recommendations for the whole health workforce and oversight of immediate actions to mitigate workforce issues, and has started scoping some initiatives that could help to ease underlying workforce pressures over the coming year:

21.1 development of a recruitment/registration pathway for internationally qualified health professionals;

21.2 strengthening the health workforce education pipeline; and

21.3 strengthening the General Practice Training Pathway.

22 In addition, there are four international nursing recruitment campaigns either underway or planned:

22.1 critical care nurses - targeting New Zealand trained and internationally-qualified nurses;

22.2 general nursing campaign due to go live at the beginning of August 2022; and

22.3 attending a nursing job event in Singapore where there have been over 200 registrations from nursing students keen to explore opportunities in Aotearoa New Zealand.

Initial focus of the Planned Care Taskforce

23 The Taskforce was stood up by the Chief Executives of (at the time) interim Health New Zealand (iHNZ) and the interim Māori Health Authority (iMHA) in April 2022 on my endorsement. The purpose of the Taskforce was to get ahead of 2022/23 production planning and have in place immediate interventions that could be actioned from 1 July 2022.

24 The Taskforce terms of reference identified a number of initial deliverables. These have been delivered as scheduled, and a summary of the initial analysis can be found in Appendix 1:

24.1 the first deliverable of the Taskforce was to provide the Chief Executives of iHNZ and iMHA with a list of Pae Tata (Near Horizon) opportunities that could be implemented and/or explored as matters of urgency to begin improving planned care delivery. This was completed in April 2022;

24.2 following the opportunities identified in Pae Tata, in mid-May the Taskforce communicated with District Health Boards, requiring each of them to take action in initially specified areas of focus;

24.3 on 31 May, the Taskforce delivered a report confirming availability and feasibility of private and public production capacity for the 2022/23 year to the Chief Executives of iHNZ and iMHA; and

24.4 on 30 June, the Planned Care Taskforce Production Capacity update was provided to Chief Executives. This provided an update of emerging understanding of demand and capacity across key elements of planned care service delivery including referrals, diagnostics, assessment and treatment services (Refer Table 1, Appendix 1).

25 The Taskforce recommended immediate actions that are being scoped for implementation:

25.1 the addition of public cases to be added to private lists where capacity exists. Negotiations are underway with a national specialist group (NZ Orthopaedic Association) to negotiate this with their endorsement. This will provide a template to explore with other surgical subspecialties with high wait lists (i.e., plastics);

25.2 institute regional wait lists with regional clinical leadership to assess consistency in how patients are assessed and referred to wait lists. This will go some way to addressing and making transparent the consistency in how Clinical Priority Assessment Criteria (CPAC) scores are applied and is a critical enabler of equity across a region;

25.3 where it is practical, patients will be offered opportunities to get their surgical planned care outside their district. This already happens in some areas (e.g., Timaru Hospital provides some care to people living in Dunedin and Christchurch, and Taranaki/Wairarapa patients travel to Palmerston North for some specialist care);

25.4 Te Whatu Ora is also considering expanding Primary Options for Acute Care (POAC) that can provide primary care a fee-for-service to undertake diagnostics directly without referring to hospitals and be accredited to undertake some specialist assessments or pre-referral activities (e.g., pipelle biopsy) that will further take pressure off hospital wait lists. This will require parallel work with primary care to shift high

volume, lower complex work to other settings (e.g., immunisation and screening in NGOs) to mitigate concerns that shifting care will affect the viability of practices; and

25.5 reviewing all cases over 12 months to assess whether they should still be on wait lists (e.g., take off patients who may have received care acutely).

Development of the Reset and Restore Plan

26 There are many other actions that will take some time to institute. These actions will be documented in a "Reset and Restore Plan" to be provided to the Te Whatu Ora and Te Aka Whai Ora Chief Executives and Boards before the end of July 2022. The Government Policy Statement requires a planned care plan to be produced by end of September. Due to the urgency, Te Whatu Ora and Te Aka Whai Ora may provide a plan to me well before then. It will incorporate:

26.1 an indication of the actions and anticipated short and medium-term outcomes expected;

26.2 an indication of the timeframes and cost for overall backlog reduction;

26.3 advice on how Te Whatu Ora will measure, monitor and evaluate itself against this plan;

26.4 how it intends to use the COVID-19 Response and Recovery Plan (CRRF) planned care backlog funding in 22/23; and

26.5 how it will build on lessons from existing initiatives, and international experiences.

27 Medium-term actions will include:

27.1 long-term agreements with private hospitals to secure capacity at a price that is sustainable, offering certainty for those providers with a national price book on procedures offered across the country (e.g., colonoscopy, endoscopy);

27.2 expanded POAC to do more and/or fund referrals that avoid hospital admissions or requirements to attend public hospital clinics;

27.3 regionally planned theatre utilisation between hospitals and, where required, movement of teams across sites;

27.4 nationalising pathways to enable allied health in primary and community settings to deliver some pre-specialist assessments (e.g., physiotherapy on musculoskeletal pathway) and be paid fee for service to enable private capacity to provide support; and

27.5 working with national radiology networks to expand access e.g., mobile radiology services for geographically challenged communities, flexing approaches to access to CT, MRI waiting over high priority groups.

28 Following this, Te Whatu Ora will provide me with further advice, by the end of October, covering:

28.1 an assessment of the plan including prioritisation, achievability and the use of funding;

28.2 the approach to monitoring of the plan; and

28.3 any recommended changes to planned care policy or Ministerial expectations regarding delivery and waiting times in light of the plan.

29 If Cabinet agrees, I will update Cabinet of progress on the Taskforce in October 2022.

Evolution of Care in the Community

30 Care in the Community was rapidly stood up in August 2021 to manage the high volume of COVID-19 cases in the community and to minimise the burden on our health system and managed isolation and quarantine settings. It has helped COVID-19 cases and their household contacts to safely self-isolate with the appropriate clinical health, housing, and manaaki support, enabling them to comply with the requirement to self-isolate to minimise wider COVID-19 transmission.

31 To ensure the initiative was appropriately supported, in December 2021, Cabinet allocated $594.505 million in appropriated funds for delivery of the health component of Care in the Community [CAB-21-MIN-0555 refers].

32 Since December 2021, the Care in the Community model has continued to evolve to meet the needs of COVID-19 cases, their household contacts, and the challenges posed by Omicron. It has also minimised the impact of COVID-19 on the wider health system, including our hospitals. Approximately 96% of COVID-19 positive people have been able to remain in their homes or alternative accommodation, significantly minimising the impact on primary and secondary healthcare providers. This represents more than 1.2 million people.

33 To achieve this, Care in the Community has established a model of care within the health and disability system, including:

33.1 establishing four Regional Coordination Centres to assist cross-regional initiatives, e.g., workforce sharing and patient transfer options;

33.2 creating 53 care coordination hubs (including 18 Māori/iwi, three Pacific, and two ethnic community hubs) offering a single point of contact for COVID-19 patients, the local delivery of Care in the Community outreach, and co-location of services and partners. Each care coordination hub may have between 10 – 100 staff, depending on its model and needs of the community with collaboration at a local level

between care coordination hubs, former DHBs, primary care, Māori, and Pacific health and manaaki providers, pharmacy, emergency ambulance services, and central agencies;

33.3 development of the self-management and active-management clinical pathways, to ensure clinical support is focussed where it is most needed. Since 1 February 2022, 1,207,644 patients have been managed through Care in the Community, with 1,162,842 (96%) passing through the self-management pathway, and 44,802 (3.7%) supported through active management;

33.4 rollout of the oral therapeutics Paxlovid and Molnupiravir, guidance and patient information;

33.5 working to reduce inequity in the health and disability system so populations most at risk and/or isolated have access to appropriate clinical health and manaaki support e.g., the percentage of Māori and Pacific COVID-19 cases contacted within 48 hours has been consistently above 82% and 75% respectively through to May 2022; and

33.6 working to significantly strengthen key engagement and support with the disability sector through provision of a $2 million grant fund for COVID-19 disability support, and developing a workplan for improving the COVID-19 response for disabled people.

34 In March 2022, Cabinet invited a report back on the future Care in the Community strategy, and in April 2022 to outline the transition and evolution of the health component of Care in the Community [SWC-22-MIN-0054 and SWC-22-MIN-0064 refer].

35 In June 2022, Cabinet agreed to an in-principle transfer of $186.155 million of the forecast unspent Care in the Community funding from the 2021/22 financial year to 2022/23. It was forecast that this would last until December 2022.

36 Care in the Community has shown that a holistic healthcare approach can improve outcomes and help and reduce health inequities. Its overall success has been achieved through technologically-connected systems at a national, regional and local level and collaborative partnerships across government, former District Health Boards, primary care, Māori, Pacific and community providers, pharmacies, emergency ambulances, and our health and welfare systems.

37 There are two key parts to the evolution of the health component of Care in the Community:

37.1 until COVID-19 measures, including self-isolation, are not required, Care in the Community must support people and whānau to self-isolate safely. It also needs to adapt for new variants, as it did for Omicron; and

37.2 embedding elements of Care in the Community will be key to building resilience and equitable outcomes in our future health and disability system.

38 As the systems and processes developed for COVID-19 are folded back into the wider health and disability system, Care in the Community will also transition and evolve, building on and learning from its development to date. Initial planning is underway for how the 53 care coordination hubs could be integrated with localities-based care. This will bring health providers, iwi, local representatives, regional public service commissioners, and social agencies together to determine what is available and needed locally. There are important linkages with the welfare system, and any advice and decisions about future models for Care in the Community will be done in alignment with the appropriate welfare entities.

39 Officials continue to provide advice on how best to leverage Care in the Community to support the actions of the Taskforce. Te Whatu Ora and Te Aka Whai Ora will report back to me on these arrangements by 1 September 2022. This will allow for consideration of:

39.1 the right commissioning model both for Te Whatu Ora and Te Aka Whai Ora, including for primary care locality networks;

39.2 wider funding options and how existing funding can be utilised;

39.3 how Care in the Community is integrated into the future system; and

39.4 managing the risk of duplicated effort, provider expectations and funding across the system and the health and disability system.

40 If Cabinet agrees, I will report back to Cabinet in October 2022 on the evolution of Care in the Community.

Legislative implications

41 There are no legislative implications arising from this paper.

Population implications

42 The burden of COVID-19 and access to health services and planned care does not fall equally. Some populations are at much higher risk of adverse health outcomes from the virus, and disproportionate socio-economic outcomes related to access to services, including Māori, Pacific people and people with disabilities.

43 The Human Rights Commission's April 2022 report, *Inquiry into the Support of Disabled People and Whānau During Omicron* raised concerns regarding:

43.1 disrupted access to disability support services; and

43.2 upholding the right of disabled people to enjoy the highest attainable standards of health. This included concerns related to both providing

care to people who have tested positive for the virus, and wider issues with equitable access to timely high quality health services for disabled people and their whānau during the pandemic response.

44 A number of actions have been taken across government to respond to the needs of the disability community during COVID-19, for example, standing up a COVID-19 information hub for disabled people, making a 0800 number available to assist disabled people impacted by COVID-19 disability workforce shortages, and ring-fencing additional funding to support the disability community's welfare needs.

45 To mitigate the risk of inequitable outcomes, we will continue to develop our planned care and Care in the Community programmes of work and on ground implementation of initiatives, with a focus on equity.

46 This includes putting in place targeted protections for those most vulnerable and adjusting our approaches as required to mitigate the cumulative effects that COVID-19, extended wait times and specific actions throughout the course of diagnostic and treatment have on the five keys areas of the social determinants of health.

Te Tiriti o Waitangi Analysis

47 The Crown's obligations to Māori under the Treaty of Waitangi require active protection of tāonga, and a commitment to partnership that includes good faith engagement with, and appropriate knowledge of the views of iwi and Māori communities. In the context of our response to and future management of planned care and Care in the Community, this involves considering what will support a national Reset and Restore Plan alongside a seamless transition of Care in the Community that is co-ordinated, orderly, and proportionate, considering the Crown's obligation to actively protect Māori health, interests and rangatiratanga.

48 The current outbreak has so far had a disproportionate effect on Māori. Māori are at higher risk of COVID-19 infection, hospitalisation, and death due to inequitable vaccination rates, incidence of pre-existing health conditions and structural factors (for example, housing deprivation). A secondary consequence of this is that Māori service providers are experiencing high degrees of fatigue in the workforce. Health system preparedness, readiness and resilience activities must account for this, and effort must be made to support the recovery and sustainability of these providers so that they can continue to best meet the acute and longer-term needs of their communities.

49 The Government has committed, through Budget 2022, to provide a funding increase to the Māori Provider Development Scheme to secure primary and community care innovation developed by Māori providers during COVID-19 and support this capability in the new health system. Budget 2022 also includes additional funding for a range of initiatives targeted at improving primary and community care responsive to Māori and supporting Māori led approach to population health and prevention.

Human rights

50 There are no human rights implications associated with this paper.

Consultation

51 This paper was prepared by Te Whatu Ora. The following agencies have been consulted: Ministries of Health, Social Development, Education, Pacific Peoples, Te Arawhiti, the Treasury, Te Puni Kōkiri, Oranga Tamariki, Ethnic Communities, Whaikaha/Disabled People and the Public Service Commission, the Department of the Prime Minister and Cabinet, and Te Aka Whai Ora - Māori Health Authority.

Proactive release

52 This paper will be proactively released following Cabinet consideration.

Recommendations

The Minister of Health recommends that the Committee:

1. **note** the progress made by the Planned Care Taskforce; and
2. **note** the approach to transitioning COVID-19 Care in the Community into a more enduring and sustainable way of working.
3. **invite** the Minister of Health to report back to Cabinet on COVID-19 Care in the Community and the Planned Care Taskforce in October 2022.

Authorised for lodgement

Hon Andrew Little

Minister of Health

Appendix 1: Health System Planned Care Taskforce initial analysis

Production capacity availability

1 The Taskforce has analysed production capacity (public and private) availability and feasibility of delivery for the 2022/23 financial year. Analysis considered existing demand including: breakdown by ethnicity and compliance with maximum waiting time, typical capacity, and additional volumes required to address excess waiting times.

2 The analysis shows that the pandemic and winter pressures continue to have a bearing on both acute medical demand and staff capacity through illness. This has led to a further increase in the number of long-waiting patients, which has disproportionately affected Māori.

Table 1 High level breakdown of production capacity

Indicators	March 2022	May 2022	Change in metric	
Total on Elective Services Patient Flow Indicators (ESPI) 5 waiting list	64071	66931	**2860**	↑
Total waiting more than 4 months	26577	29946	**3369**	↑
% waiting more than 4 months	41%	45%	**4%**	↑
Months Forward Load (MFL)	4.9	5.1	**0.2**	↑
Total additional volumes to achieve MFL = 3	25411	28235	**2824**	↑
Total waiting more than 12 months	3723	5267	**1544**	↑
Total Maori waiting more than 12 months	695	1028	**333**	↑
Total Pacific waiting more than 12 months	177	234	**57**	↑

3 While there is insufficient workforce and capacity to carry out this work immediately, if it were possible to procure the capacity required to reduce the forward load of committed work to that which normal capacity would provide in three months, the cost would be $222.8M based on FY 2021/22 price structures.

First Specialist Assessment

4 The number of people waiting for First Specialist Assessment (FSA) longer than four months for treatment has trebled, from just over 8000 (8153) in February 2020 to 30% (n=29,649) of all patients on FSA waiting lists at the end of March 2022. This was as a result of existing constraints, compounded by increased demand for acute services, limits to activity associated with community and hospital COVID-19 management settings, and the requirement to deploy staff to other tasks

5 Based on existing trends, if no remedial activity is pursued, it is forecast that by December 2022, this will deteriorate further with nearly 10,000 more

people, resulting in 37% of all patients (n= 39,286) waiting more than four months for their FSA.

6 To maintain confidence in the health system, there is a need to demonstrate that it can provide the care to which it commits. To achieve this, capacity needs to be created or released from other activity and clinical pathways put in place that ensure accepted referrals match the capacity available to provide the committed planned care. This will be addressed in the Reset and Restore Plan.

Follow-ups

7 A recurring theme in the international experience has been that a review of the levels of outpatient follow-ups being conducted provides an opportunity to release clinical capacity for other high value activity.

8 Between 2018/19 and 2020/21 medical follow up appointments provided in New Zealand have increased by 14% to ≈470,000 and surgical follow-ups have increased by 10% to ≈780,000. A detailed review of outpatient follow-ups by speciality is underway to determine the scale of the opportunity for re-deploying capacity.

Diagnostics

9 Provision of radiology (primarily X-Ray, CT and MRI) and endoscopy is a key step in the provision of planned care. In some clinical journeys this precedes triage and FSA, in others it is required throughout the journey either on a one-off or ongoing basis. Waiting times for diagnostic work are longer than desirable in many settings. Work towards providing a consolidated view is ongoing.

Private sector capacity

10 There is limited visibility of third-party provider capacity immediately available at a local and regional level. The New Zealand Private Hospital Association is working to respond to the Taskforce's request for an updated operational view of capacity available to support Health New Zealand funded planned care service delivery. An updated stocktake of private capacity will provide a better understanding of capacity; this is due in mid-August 2022.

11 In the interim, Te Whatu Ora Regional Directors have been asked to continue existing outsourcing commitments to enable the baseline level of production to continue. This has proceeded variably throughout the country as a result of a variation in budget pressures and the variation in private sector negotiating positions. Regional funding leads will be working with providers in their regions, as well as with other regional leads, to procure capacity and ensure it is targeted appropriately.

12 Some districts and regions have contract arrangements in place to enable the short and medium-term use of third-party capacity. However, agreements are not in place in all districts and regions to facilitate immediate use of any available marginal capacity should this be required.

13 Private hospital capacity can be used in the months of July, August and September to mitigate the reduction in planned care capacity. To do so requires a concerted effort to:

13.1 locate, negotiate for, and implement marginal capacity arrangements in private facilities; and

13.2 identify the types of cases that can be provided in a private setting using the existing agreements in place with a focus on ensuring highest clinical priority patients and longest waiting patients are prioritised to receive planned care.

14 In each region, officials will ensure plans are in place to:

14.1 enable the use of third-party capacity for July – September;

14.2 ensure there is no reduction in the use of this capacity; and

14.3 enable increased use where this is possible, subject to developing budget and delegation processes.

15 Within existing delegations and practice, Regional Directors have been instructed to continue to ensure active use of outsourced and outplaced theatre, endoscopy and radiology capacity to maximise care provided during the winter period.

16 There are already approaches to provide specialist services that cross regional boundaries. In addition, Regional Directors have been instructed to develop, run, and evaluate district and service level reports of long waits (FSA and Treatment) and promote regional approaches.

17 In the longer term, Te Whatu Ora and Te Aka Whai Ora will review approaches to the use of third-party capacity to enable best use of all public and private capacity that can support the delivery of planned care. Future actions include completing a strategic commissioning process for a national framework and national and regional procurement of private surgical and diagnostic capacity within agreed financial parameters to enable implementation from 1 July 2023.