~~In Confidence~~

Office of the Minister of Health

Cabinet Social Wellbeing Committee

Reducing wait lists for planned health care

Proposal

1 This paper reports on prioritised actions for measurable improvements in wait lists for planned care. This is an important matter I have been progressing with Te Whatu Ora - Health New Zealand, consistent with my Letter of Expectations 2023/24.

Relation to government priorities

2 The Government is committed to protecting, promoting and improving the health of New Zealanders, and achieving equitable health outcomes, in line with the purpose and principles set out in the Pae Ora (Healthy Futures) Act 2022 (the Pae Ora Act), te Tiriti o Waitangi and Wai 2575: Health Services and Outcomes Kaupapa Inquiry (Wai 2575). The actions described in this paper support achieving these goals to reduce wait lists for planned care through to June 2024.

Executive Summary

3 This paper sets out the actions that Te Whatu Ora is taking to manage the delivery of planned care services in the health system.

4 Reducing wait lists is one of my top priorities. Alongside specific actions to reduce wait lists, making progress on my other two priorities – winter and workforce – will improve the system's ability to deliver timely, safe, and effective health services. There are also planned care actions that have been designed to ensure more equitable outcomes for Māori and other population groups, as required under the Pae Ora (Healthy Futures) Act.

5 Planned care delivery is a challenge in New Zealand, with people now waiting longer for care than at the start of 2022. This is due to the impact on planned care services from acute demand, the legacy of planned care restrictions due to COVID-19, and workforce constraints (vacancies, illness, leave).

6 COVID-19 has exacerbated long standing challenges which has put pressure on planned care recovery. This issue is not specific to New Zealand, and other countries are struggling with wait times for planned care.

7 The Planned Care Taskforce was set up in May 2022 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. The Taskforce's Reset and Restore Plan made 101 recommendations on actions required to achieve these objectives.

8 In October 2022, a multi-year implementation programme commenced to address the Reset and Restore Plan's recommendations. This includes the development of an implementation plan through to June 2024 with actions focused on addressing the Planned Care Taskforce's recommendations.

9 Actions set out in the implementation plan are focused on reducing wait lists for both first specialist assessments and for treatment, ensuring that this is managed in an equitable way and that clinical prioritisation of patients is nationally consistent. Delivering on the action plan will see no people waiting longer than 365 days for treatment treated by 31 December 2023 (excluding orthopaedic surgery) and ongoing stabilisation of wait lists and improved ethnic and geographic equity through 2024 and beyond.

10 These actions will be supported by the theatre optimisation work that is focussed at making best use of theatre capacity across districts to deliver surgical procedures. Actions will also explore the use of clinical pathways and service models to ensure that patients can receive care in primary and community care settings when clinically appropriate.

11 In addition to baseline funding, further funding has been made available to 30 June 2023 to increase surgical and diagnostic volumes, and to initiate other actions set out in the Reset and Restore Plan. This additional funding for initiatives focuses on prioritising Māori and Pacific people who have been waiting over 365 days for planned care.

Background

12 On 16 March 2023, the Letter of Expectations to Te Whatu Ora – Health New Zealand set out my immediate service priorities, and the delivery of these priorities, for the 2022/23 financial year relating to workforce, winter and wait lists.

13 Reducing wait lists is one of my three key priorities for the health portfolio and sits alongside priorities for winter preparedness and the health workforce. This paper sets out how Te Whatu Ora intends to reduce wait lists over time, including actions to achieve equitable outcomes.

14 The three areas of wait lists, winter preparedness and workforce are interrelated and dependent on each other to succeed. Winter preparedness and the associated work on improving acute flow will reduce the impact of acute care on delivery of planned care. The winter preparedness plan includes monitoring length of stay (for the purposes of freeing up bed space for better acute flow and inpatient procedures[1]) and planning increases to the proportion of day case surgery through the predicted weeks of winter surges (to enable day surgery to proceed even if beds are not available for inpatient procedures).

[1]Inpatient procedures are those planned care procedures that require an inpatient stay in a hospital (eg hip replacement, cardiac surgery).

15 Similarly, workforce is a key constraint in delivery of planned care, particularly for multidisciplinary surgical teams – without the workforce, we cannot deliver planned care.

16 In April, I updated Cabinet on Te Whatu Ora's plans to prepare for and mitigate, the impact of winter 2023 on delivering health services [CAB-23-MIN-0107 refers] and Cabinet will soon be updated on the approach to address workforce constraints.

Planned care challenges

17 Globally, health systems are experiencing acute pressures in planned care delivery following the COVID-19 pandemic. Available data show that Canada and Australia both experienced significant deterioration in wait times in 2020 (higher than New Zealand), before returning closer to, but still above, pre-pandemic wait times in 2021 (similar to New Zealand).

18 Within New Zealand, people are now waiting longer for care than at the start of 2022. People are entering the wait lists at faster rates than in the past, contributing to the wait lists getting longer before they can be reduced. Further, as at 7 May 2023, the over 12-month wait lists for people waiting for planned care is 5,614 (up from 4200 in 2022).

A range of factors contribute to the pressure on planned care

19 The challenges in planned care are primarily a result of high acute demand[2], the legacy of planned care restrictions due to COVID-19, and workforce constraints (for example vacancies, illness, and leave). Capacity pressures, including high levels of acute demand and workforce challenges, limit the scope to rapidly reduce wait times as they reduce the availability of beds for inpatient procedures. Inequitable access to services, particularly for Māori and Pacific whānau, and between different parts of the country, compound the impact of these challenges.

20 Timely discharge from hospital enables planned care to deliver services as scheduled. There are some types of discharge arrangements that may have an adverse impact on planned care delivery. This can include situations where discharge is dependent on availability of aged residential care or rehabilitation beds.

21 Another example is when patients returning to their own homes who require ongoing community support are unable to access support services on their discharge from hospital. These factors can contribute to a higher average length of stay in hospital using beds that cannot then be used for new planned care patients. In the week ending 19 May 2023, the number of patients in hospital for 7 days or longer was 1,526. This is an 11.5% increase on the same week in 2022, and part of an overall rising trend.

[2] Acute case weighted discharges have increased by over 1.5% per year since 2019.

There is some stabilisation in planned care delivery but ongoing pressure

22 As at March 2023, the delivery of planned care interventions is reported as 106.2% against planned delivery (see Appendix 1 for a breakdown by region and district). However, when this figure is interrogated, inpatient procedures are at 86.9% against plan and 144.9% of planned minor procedures have been delivered.

23 The report against plan (for the delivery of planned care services) indicates that the health system is delivering more care within resources than planned. However, there are still large numbers of people on the wait list and people are waiting longer for these treatments. This is both due to lower than planned performance on inpatient discharges, combined with increasing numbers joining the wait list.

24 Variation geographically and by specialty continues across the country. Confirmation of sustainable, positive impacts on long waits for Māori and Pacific patients will take time as initiatives and data collection is bedded; this remains a priority.

25 Despite the challenges, the Northern region is showing reduction in wait lists that can be achieved. The number of patients waiting over 365 days for treatment has reduced from over 1800 in July 2022 to 870 in May 2023 and is projected to fall to 440 by 30 June 2023.

26 This result has been achieved through strong clinical and operational leadership, high quality data, and a daily focus on delivering planned care to the longest waiters while meeting acute care needs. It has also required strong collaboration between districts, which has been enabled through the health system reforms and the adoption of new, regional approaches.

National approach to tackling planned care demand

Planned Care Taskforce

27 The Planned Care Taskforce was set up in May 2022 to coordinate commissioning of planned care and engage with clinicians on prioritisation of activity for planned care delivery.

28 The Taskforce was specifically charged with considering equity across its recommendations, specifically for Māori to give effect to te Tiriti o Waitangi. The Taskforce also considered equity for Pacific people and tāngata whaikaha and looked at support for people experiencing challenges due to where they live, and for those who are not accessing health services equitably.

Reset and Restore Plan

29 The Planned Care Taskforce's Reset and Restore Plan, finalised in September 2022 and released on 25 October 2022, made 101 recommendations 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.

30 In October 2022 a multi-year implementation programme commenced to address the Reset and Restore Plan. The Reset and Restore Plan recommendations are being implemented in groupings aligned to the patient's experience throughout their planned care experience. These also consider planned care priorities to create nationwide standardised processes such as data validation and quality, and criteria for services to reduce wait lists for assessment and treatment and insulate planned care from the impact of system pressures.

Implementation plan for planned care actions

31 The implementation plan, set out in the Summary of Initial Planned Care Actions (Appendix 2), outlines the next steps to deliver on the recommendations. These actions follow on from activity during the 2022/23 year to plan and implement 63 of the 101 recommendations (focus on long waiters, improving data and analytics, establishing governance and networks, primary and community care, theatre utilisation, clinical pathways, clinical prioritisation, care navigation). Actions are sequenced for delivery through to June 2024. Appendix 3 contains progress status of all 101 recommendations as of the Reset and Restore plan.

32 The plan includes the following areas of focus: reduction of treatment wait lists, reducing inequity in long waiters for treatment, reduction of wait list for first specialist assessment, theatre optimisation, clinical prioritisation, clinical pathways and innovative service models.

33 The work we have underway as part of the winter plan will also help us improve delivery of planned care through addressing system pressures on our hospitals and protecting planned care capacity.

Reduction of treatment wait lists

34 The immediate focus is on addressing all patients (fewer than 25) who are waiting more than three years for treatment by 30 June 2023.

35 By 31 December 2023, we expect no patients (excluding those waiting for orthopaedic surgery) to be waiting longer than 12 months for treatment, from the date a decision to treat is made.

36 This will be achieved through investing in timely and effective provision of hospital and specialist services. We are also fundamentally shifting elements of planned care delivery by exploring and maximising capacity in other parts of the system that have been underutilised in the past, e.g., primary care and the private sector, along with driving further efficiencies from our public facilities.

37 s 9(2)(b)(ii), s 9(2)(g)(i) [redacted]

s 9(2)(b)(ii), s 9(2)(g)(i)

38 Te Whatu Ora is actively engaged with the New Zealand Private Surgical Hospitals Association, and unaffiliated private hospitals, to utilise any remaining marginal capacity that may exist without drawing resources out of public hospitals. The private sector's advice is that a further 10-20% additional capacity could be available, with sufficient notice.

39 Addressing the orthopaedic wait lists will take longer due to the availability of specialist surgeons and resourced capacity. However, Te Whatu Ora is progressing orthopaedic treatment through three main approaches: outsourcing to private hospitals; increasing capacity of public hospitals by adding Saturday theatre schedules; and through the musculoskeletal pilot to reduce demand for surgery.

40 Due to the size of wait lists, where clinical need is the same, Te Whatu Ora is committed to clear the longest waiting patients first. As these milestones are achieved, it will give greater confidence to commit to forecasting reducing lists for patients waiting over four months for treatment.

41 It will be important to conduct a systematic process of data validation, case review of individual patients and urgent treatment provision to ensure we are achieving these milestones. This involves all four regions actively reviewing their wait lists and participating in regular nationally led 'wait list stand ups' to work through action being taken for every patient in each cohort. This approach requires a close partnership between clinical leaders and operational managers to manage wait lists and theatre schedules closely.

42 In conjunction with the above, an initiative to establish nationally consistent, proactive communication with patients has commenced. The first activity, in May 2023, is to contact all patients waiting between four months and three years for treatment by letter or email.

43 This communication, translated into seven languages, will acknowledge to patients that their treatment has not been provided in the time frame they were expecting, outline the reasons for this and request that they contact Te Whatu Ora to update their contact details and advise if they have received their treatment privately. The communication will also inform patients what to do if they feel their condition has deteriorated.

44 In addition to each patient receiving communication during the same time period, the information they provide in response will inform the wait list data validation processes currently underway.

45 Te Whatu Ora is ensuring that each district has appropriate risk management processes and practices in place around reviewing lists. As part of Reset and Restore, there is a commitment to implement a national access and choice

booking policy that will improve consistency of patient bookings, and monitoring and reporting of wait lists.

Reducing inequity in long waiters for treatment

46 An equity adjuster for wait list management has been implemented in some districts and specialities in the Northern Region. The equity adjuster is an algorithm which uses ethnicity, rurality and social deprivation categories to guide the priority with which booking teams schedule patients for treatment. It works to adjust the order in which patients with the same urgency are scheduled for treatment, rather than changing the urgency band to which a patient is allocated.

47 The use of a process that has high regard to equity considerations is imperative to ensure patients are scheduled for treatment in an equitable way, so people are treated in the right order. This approach is particularly important to ensure Māori and Pacific people, people with disabilities, those who are socially deprived, or live in rural areas are scheduled for treatment and actively supported to receive treatment. This reduces current inequities which results in them becoming long waiters at a disproportionately higher rate to other patients on the wait list.

48 It is anticipated that the equity adjuster will be implemented across the Northern Region by 31 August 2023 and rolled out nationally by 30 June 2024.

49 The National Radiology Advisory Group is also interested in applying this approach to their wait lists and are organising a demonstration of the equity adjuster tool to NRAG.

Reduction of wait list for first specialist assessment (FSA)

50 The approach for reducing wait lists for treatment will be applied to reducing wait lists for FSA. This includes improving data quality and validation, reviewing wait lists at the individual patient level and utilisation of the equity adjuster.

51 The reduction of the wait list for treatment has been the main focus to date. The focus on assessment wait lists commenced in May 2023.

52 It is important to note that as long waiters for FSA are reduced, the volume of patients being added to treatment wait lists will increase. As part of the work to reduce FSA wait lists, Te Whatu Ora will be performance managing each stage of a patient's journey into planned care.

Theatre optimisation

53 Currently, there is high level of variation between districts of the definitions and metrics used to measure how efficiently operating theatre space is used, for example, start and finish times and what is counted as a late start to an operating list. Therefore, to understand if theatre capacity is being maximised,

the available theatre space needs to be known and how the utilisation of this space is measured needs to be consistent.

54 A newly formed theatre utilisation expert advisory group (TEAG) has recently undertaken a stocktake of the current national physical theatre capacity. The results are currently being collated and reported.

55 The TEAG is also in the process of agreeing nationally consistent metrics to measure the utilisation of available theatre capacity. The metrics will be based on those the Northern Region is already using in some districts. Once agreed, in May, the metrics will be rolled out in the Northern region and then implemented in the other three regions.

56 The target is that from 1 January 2024, the utilisation of all theatres will be measured and reported consistently, providing data to inform activities required to maximise the use of public theatre facilities and workforce, which, in turn, will contribute to reducing the waiting time for surgery and identification of additional capacity required.

57 Whilst the above activities address those already on the wait lists, activities will take place in parallel to address how people access the wait lists for assessment and treatment.

Clinical prioritisation

58 Clinical prioritisation remains the foundation for the order in which patients are treated. There are several variances in how this is applied at a district level, resulting in a 'post code lottery' for services. It is important that there is a nationally consistent approach applied to these decisions.

59 A decision on a nationally consistent approach to clinical prioritisation is being confirmed. This will guide the development of criteria for access to assessment and treatment in each clinical specialty. The application of the national approach will be phased. The first tranche of specialties will agree nationally consistent access criteria by 30 September 2023.

60 Some specialities are actively addressing this issue, for example, cataract surgery (as outlined in paragraphs 62 to 69 below) and hernia surgery in the Northern region., Such initiatives will enable consistent approaches to clinical prioritisation throughout the motu, reducing regional variation in access. .

61 It is anticipated that the next tranche of specialities will agree their criteria by 30 November 2023. The newly established clinical networks will contribute to this activity.

Clinical prioritisation activity: Access to cataract treatment

62 Aligned with this approach is the targeted project to address the current inconsistency across districts in usage of cataract treatment threshold.

63 Currently, there are regional discrepancies in access to cataract surgery, with some districts providing access at levels different to the standard access threshold.

64 The standard access criteria will be a visual acuity threshold (cTT) score of 46. At present thresholds for access to Cataract surgery range from 46 to 61 across different districts. A score of 46 represents mildly reduced vision in each eye. A score of 61 represents poor vision in both eyes which is below the level required to legally drive and has a significant impact on a patient's independence and quality of life.

65 Most patients will still only be able to access surgery on one eye at a time for clinical safety reasons. Exceptions will include where they have another eye condition that will be aided by cataract surgery, such as glaucoma, or have diabetes and require cataract surgery to allow ongoing screening for diabetic eye disease. By the end of May 2023, Te Whatu Ora will have information on the status in each district of patients who meet and the standard threshold and require treatment.

66 Once the volume of additional patients that meet the treatment threshold is understood, together with the forecast of likely volumes to be treated, and the cost and resource required to respond has been established, funding will need to be committed and an implementation plan prepared.

67 It is anticipated that prioritisation activities to support access to cataract surgery actions to treat additional patients will commence in July 2023. Monitoring of the implementation plan and reporting of progress will take place regularly.

68 Through a combination of continued outsourcing, insourcing, changes to clinical pathways and productivity improvements, Te Whatu Ora will ensure that volumes for treatments can be achieved in regions with longer wait lists.

69 The completion date for addressing the additional volumes will not be known until the volumes in each district have been established. A timeframe of 30 June 2024 is estimated at this stage.

Clinical pathways and innovative service models

70 To reduce wait lists, increase hospital-based planned care capacity and provide services to patients in their communities, innovative service models that deliver a 'step change' in how services are delivered are in development.

71 Additional funding to reduce treatment wait lists has been allocated to prototype a new musculoskeletal community service delivery model. This utilises physiotherapists to provide the initial assessment of patients presenting with orthopaedic issues, instead of surgeons, and to then provide intervention in the community, when clinically appropriate, rather than surgery. This will release surgeons to treat more patients and reduce the assessment and treatment wait lists.

72 Separately, there is also an equity-focused bariatric (obesity) initiative is underway to address unmet need in Māori and Pacific communities.

73 This focus area also includes the exploration of general practice teams delivering appropriate procedures in the community.

74 Appendix 2 provides detailed information on these focus areas and actions, including the implementation timeframes and expected impact and funding implications. Whilst none of these activities alone will achieve the required improvement in access to treatment, as they come to fruition by June 2024, and beyond, the collective impact will improve access and treatment times and provide a foundation to create models of care for other specialties and services.

Enablers for successful implementation

75 To deliver the initiatives outlined above and the anticipated improvements in planned care, it is vital that the enablers of these activities are in place and strongly supported.

76 The main enabler is ensuring that we have an adequate workforce to deliver health services. Sufficient capacity and the right mix of skills amongst our workforce remains the single biggest constraint to improving the delivery of planned care. A key initiative in this space is the establishment of an Anaesthetic Technician Technical Group to reinforce activities to recruit and retain anaesthetic technicians which will have a positive impact on actions to support theatre optimisation. Further detail on workforce initiatives will be provided in a paper on workforce actions that I will shortly bring to Cabinet.

The health reform provides a unique opportunity to improve planned care

77 While the impact of the health reforms will take time to be fully realised over the next five to ten years, there are some early signs of progress.

78 Bringing together 20 district health boards into one Crown entity has enabled districts and regions to increasingly work together on service delivery, data quality and reporting. The reduction in variation across specialities and districts and promotion of unified, nationally consistent processes, systems and initiatives is leading to the maximisation of capacity and experience to improve access to and timeliness of treatment.

79 Although patients have previously received planned care services in other districts and regions, increasingly teams are taking a regional approach to planning and use of capacity. This includes patients travelling to access treatment or clinical teams travelling to deliver services within and between regions.

80 Since February 2023, patients in South Canterbury have been able to undergo maxillofacial surgery in their district at Timaru hospital. The first surgeries were carried out by a Christchurch based surgeon, supported by Timaru hospital-based teams. Cooperation between hospital services teams

across Timaru and Christchurch hospitals (including theatre equipment) and other teams from the wider Te Waipounamu region enabled the success of this initiative.

Clinical networks will help drive planned care initiatives

81 Te Whatu Ora's approach to clinical networks will see a clinical-operational partnership approach to managing health services, drawing on the expertise of interprofessional networks, including nursing, midwifery and primary care.

82 The clinical-operational partnership is critical in achieving the planned care actions as it will enable the identification and implementation of operational improvements such as optimising use of existing theatre capacity and workforce. National and Regional Clinical Networks will be set up to support clinical governance and focus on national and regional priorities.

83 The National Clinical Networks will:

83.1 Be in place in 11 service areas from 1 July 2023

83.2 Develop national standards and models of care

83.3 Identify ways to address variation in service quality and outcomes

83.4 Model co-leadership with Māori clinicians co-chairing all networks

83.5 Develop innovative, efficient and evidence-based solutions that can be applied nationally

83.6 Provide clinical and equity approaches

83.7 Enact a partnership approach with te Tiriti and its principles as a foundational underpinning of its structures and functions.

84 The Regional Clinical Networks will:

84.1 Focus on the delivery of safe, high-quality, patient and whanau centred services within their region

84.2 Have dedicated clinical and managerial leadership

84.3 Operationalise the models of care, standards and initiatives developed by the National Clinical Networks

84.4 Ensure that the partnership between clinical and equity leads and operational and strategic management enables delivery of improvements in service access, patient and whānau experience, and outcomes particularly for Māori.

85 The work of the Networks will be pivotal in enabling the delivery of equitable outcomes for Māori. Data and evidence-based practice will all be considered within an equity context. Planning will ensure that Pacific, tāngata whaikaha

and rural people are also sufficiently prioritised throughout the work of the networks.

86 Ophthalmology will be in the first tranche of Clinical Networks to be activated. This supports the activity outlined in sections 57 to 60 above, to deliver standardised access criteria using the Clinical Prioritisation and Assessment Criteria (CPAC) tool for cataract treatment.

Equity is a key consideration for the delivery of planned care services

87 As noted in paragraphs 46 to 49, planning is underway to introduce a nationally consistent and agreed equity wait list adjuster. The use of this tool promotes the delivery of a 'treat in right order' access to treatment.

88 In reducing wait lists, we have a specific focus on delivering equitable health services for Māori and Pacific people. This is a key component of all three priority work areas (winter, wait lists, workforce).

89 Māori and Pacific people are over-represented amongst those who have been waiting too long for their first assessment or for treatment. There are actions underway at both regional and local levels to address inequity in planned care. Two examples of regional initiatives that focus on dental surgery and bariatric surgery (briefly mentioned in paragraph 72) are outlined below.

90 Additional dental surgery will be delivered in areas where Māori and Pacific people have been waiting a long time. Services will be rolled out nationally and include additional Saturday services and outsourcing. Where possible, services already in place will be utilised such as the Mobile Surgical Services Bus capacity to provide in Te Tai Tokerau Northland.

91 Te Aka Whai Ora and the Te Whatu Ora Pacific Health team are also leading an initiative in the Northern Region to understand why Māori and Pacific patients who have been recommended for bariatric surgery are not progressing to wait lists for treatment and surgery and to identify relevant service models and support for patients.

Monitoring and reporting

92 Implementing all the actions in Appendix 2 will result in significant reduction in long waiters, starting with those waiting over 365 days for treatment (excluding orthopaedic surgery) by 31 December 2023. Through 2024, the action plan will see stabilisation in waitlists for FSA, treatment and follow up. Ethnic inequities in waitlists will continue to be reduced over time in addition to reduction in geographical variation in access.

93 Te Whatu Ora is monitoring progress against planned care initiatives through the setting of regional trajectories monitored by the Planned Care Oversight Group, and twice weekly operational meetings with the regions. Officials are in the process of establishing a dashboard that will track the metrics from the Reset and Restore plan, including all 101 recommendations.

94 In addition, I will receive monthly monitoring reports from Te Whatu Ora across all relevant milestones described above to ensure successful and timely implementation of activities to reduce wait lists.

95 As the work progresses, data is collected consistently on a local, regional, and national level and metrics are developed to measure the outcomes, Te Whatu Ora will be able to quantify the positive impact of the initiatives for patient care.

Financial Implications

96 Initiatives outlined in this paper for completion by 30 June 2023 are being funded from Te Whatu Ora's baseline.

97 The Minister of Finance recently announced $118 million in Budget 23 for the 2023/24 initiatives outlined in this paper, being:

97.1 additional outsourcing to private hospitals

97.2 additional theatre sessions, e.g., Saturdays, and

97.3 shifting planned care into primary settings e.g., the musculoskeletal initiative, diagnostic services, and expanded service provision by GPs.

98 Te Whatu Ora is also considering what funding may be required for Budget 24. Any potential bids for planned care services for Budget 24 will be discussed as part of Te Whatu Ora's Budget 24 work programme in consultation with Te Aka Whai Ora and Manatū Hauora.

99 Most actions in this paper have a specific funding source, either through Budget 2023, a previous budget decision where the revenue has transferred to Te Whatu Ora from Manatū Hauora, consolidation of existing resources, or by re-commissioning, re-design, and re-contracting of existing services.

100 Work is underway to establish a realistic plan for further recovery and improvement in 2023/24, and this will inform planning and prioritisation of available funding.

Legislative Implications

101 There are no legislative implications.

Impact Analysis

Regulatory Impact Statement

102 No impact analysis is required for this paper.

Climate Implications of Policy Assessment

103 A Climate Implications of Policy Assessment (CIPA) is not required for this paper.

Population Implications

104 Under the Pae Ora (Healthy Futures) Act 2022 (Pae Ora Act) Te Whatu Ora is required to give effect to the principles of te Tiriti o Waitangi. The Pae Ora Act requires Te Whatu Ora to be guided by the health sector principles, which, among other things, are aimed at improving the health sector for Māori and improving hauora Māori outcomes. In accordance with the health sector principles, the initiatives covered in this paper will make an important contribution to Te Whatu Ora ensuring a equitable health system.

105 An equity adjuster for wait list management has been implemented in some districts and specialities in the Northern Region and will be rolled out across the country.

106 Appropriate recognition of, and response to, equity considerations is imperative to ensure patients are scheduled for treatment in an equitable way, so people are treated in the right order. This approach is particularly important to ensure Māori and Pacific people, people with disabilities, those who are socially deprived or live in rural areas are scheduled for treatment and actively supported to receive treatment.

107 There are specific actions that will have a positive impact for both Māori and Pacific People which are described in more detail within this paper.

108 Disabled people: Actions that are set out in the Reset and Restore Programme will benefit Māori and Pacific tāngata whaikaha. Further planning will be necessary to ensure that tāngata whaikaha are prioritised for planned care activity. It will be important that planned care actions deliver for Māori and Pacific people with intersectional identities [i.e., tāngata whaikaha Māori (Māori people who are also disabled) and Pacific people who are also disabled], and that the health workforce has disability competency.

109 For example, work on the rapid automated data solution to inform decision making on booking and scheduling will need to consider how this action will deliver for disabled people, given disability status is not linked to an individual's National Health Index (NHI) number.

110 This is particularly important as the NZ Health Survey 2020/21 showed disabled people have higher un-met healthcare needs compared to non-disabled people over several domains, including:

110.1 11 percent of disabled people had an unmet need for GP services due to COVID-19, compared to 6 percent of non-disabled people.

110.2 42 percent of disabled people had an unmet need for primary healthcare, compared to 27 percent of non-disabled people.

110.3 51 percent of disabled people had an unmet need for dental healthcare due to cost, compared to 39 percent of non-disabled people.

111 Rural communities: Actions that are set out the Reset and Restore Programme will benefit rural communities. Further planning will be necessary to ensure that rural communities are prioritised for planned care activity.

112 The Summary of Initial Planned Care Actions in Appendix 2 contains more detail about population impacts of planned care actions.

Human Rights

113 The proposals in this paper are consistent with the New Zealand Bill of Rights Act 1990 and the Human Rights Act 1993.

Consultation

114 Te Whatu Ora and Te Aka Whai Ora are collaborating in partnership to manage planned care activity.

115 This paper was prepared by Te Whatu Ora. It was shared with the following agencies: Te Aka Whai Ora – Māori Health Authority, Manatū Hauora – Ministry of Health, Whaikaha – Ministry of Disabled People, Department of the Prime Minister and Cabinet, The Treasury, and Accident Compensation Corporation.

116 The Accident Compensation Corporation (ACC) noted that the actions focussed on the reduction of treatment wait lists may impact surgeries for ACC clients. Te Whatu Ora will work with ACC to understand the impact of actions and mitigations for ACC patients.

Communications

117 A communications plan has been developed to provide a clear, proactive, relevant and timely stakeholder communications and engagement to support the implementation phase of the Reset and Restore Plan ensuring it meets with the overall strategic direction of Te Whatu Ora and Te Aka Whai Ora.

118 Communications ensure that planned care initiatives are well understood with Te Whatu Ora, across the health system, and by the public. This will include engaging with health care stakeholders about each of the initiatives to ensure they are aware of the changes being made to improve planned care wait times and to showcase initiatives as they are rolled out and progress.

119 In line with the above monitoring and reporting commitments, the communications plan will also include publication of disaggregated data to ensure that all relevant stakeholders are aware of the progress across planned care initiatives.

120 Work will also be necessary to ensure that any communications are developed into alternate formats for disabled people.

Proactive Release

121 This paper will be proactively released. It will be subject to redactions as appropriate under the Official Information Act 1982.

Recommendations

The Minister of Health recommends that the Committee:

122 Note that reducing wait lists for planned care is a key priority for achieving the Government's vision for the health system reforms.

123 Note that this paper provides the high-level version of Te Whatu Ora's Reset and Restore Implementation Programme Actions.

124 Note that preparation for planned care activity is ongoing and that further initiatives for the medium to long term are under active discussion.

Authorised for lodgement

Hon Dr Ayesha Verrall

Minister of Health

Appendix 1: Planned care delivery against plan – inpatient (IP) discharges (procedures) and minor procedures by district

Region	District	IP Discharges %	Minor Procedures %	Planned Care Interventions %
Northern	Auckland	85.3%	116.9%	94.7%
	Counties Manukau	79.9%	149.4%	103.1%
	Northland	95.9%	95.4%	94.3%
	Waitemata	99.3%	143.2%	112.9%
	Total	**90.1%**	**126.2%**	**101.2%**
Te Manawa Taki	Bay of Plenty	88.4%	136.1%	106.6%
	Lakes	101.6%	130.0%	110.2%
	Tairawhiti	74.2%	138.5%	92.2%
	Taranaki	93.1%	228.3%	136.2%
	Waikato	89.1%	126.5%	101.0%
	Total	**89.3%**	**151.9%**	**109.2%**
Central	Capital and Coast	82.5%	143.2%	100.7%
	Hawke's Bay	82.5%	124.3%	93.5%
	Hutt Valley	96.2%	142.6%	109.3%
	MidCentral	78.4%	181.2%	115.0%
	Wairarapa	97.5%	252.3%	141.5%
	Whanganui	96.9%	153.0%	116.9%
	Total	**89.0%**	**166.1%**	**112.8%**
Te Waipounamu	Canterbury	72.8%	190.7%	114.9%
	Nelson Marlborough	86.5%	232.3%	133.8%
	South Canterbury	94.8%	109.1%	98.7%
	Southern	86.0%	91.7%	88.6%
	West Coast	84.1%	113.6%	96.3%
	Total	**84.8%**	**147.5%**	**106.5%**
National	**Grand total**	**86.9%**	**144.9%**	**106.2%**

Source: NBRS (March Data)

[3] Examples of IP discharges (procedures) include hip replacements and cardiac surgery. Examples of minor procedures include injections for macular degeneration and removal of skin lesions.

Appendix 2: Reset and Restore Programme Implementation Plan

Appendix 3: Reset and Restore - 101 Recommendations Progress Status