

# Planned Care Taskforce | Summary of Reset and Restore Plan Findings and Recommendations

**This Plan is the Taskforce's final requirement. It provides advice to the Chief Executives of Te Whatu Ora – Health New Zealand and Te Aka Whai Ora – The Māori Health Authority on actions to be taken locally, regionally and nationally to improve equity, increase access and reduce waiting lists for planned care.**

Leaders from Te Whatu Ora and Te Aka Whai Ora are now developing a detailed implementation plan based on the Taskforce's recommendations which promote improvements in:

Clinical consistency  
Access to knowledge, investigations and treatments at appropriate points in the planned care continuum  
Appropriate staffing, resources and productivity  
Consistency in processes including resource utilisation and scheduling  
Improved collaboration with the private sector.

## The Effect of COVID-19 on Provision of Planned Care

COVID-19 has been 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.

A major challenge is to improve planned care delivery back to pre-pandemic levels of productivity. 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 capacity allows.

While the pandemic has exacerbated the challenges faced in providing planned care, it has not created them, they already existed.

## Equity

A key reason for the health reforms is that previous iterations of the health system had failed to alleviate many health inequities.

Health inequities are unfair, avoidable and remediable. Health inequities in planned care include differing groups being disproportionately affected by delays or differences in advice and treatment options offered to patients. Health equity is only achieved when health outcomes are equitable to that achieved for others.

Several recommendations from the Taskforce promote clear analysis and presentation of data that help the system understand the provision of planned care to Māori, Pacific and others to inform future approaches to prioritisation and planning.

**Te Whatu Ora**  
Health New Zealand

**Te Aka Whai Ora**  
Māori Health Authority

## Findings detailed in the Plan – The Challenges:

**Equity:** 53% of Māori have been provided with treatment within four months of receiving certainty, compared with 58% of non-Māori, non-Pacific and 62% of Pacific – demonstrating inequity, especially for Māori

**Referrals:** Approximately 6,000 more referrals are accepted by Hospital and Specialist Services each year than are currently seen, thus waiting lists continue to grow

**Radiology:** Accurate Information about the size of the waiting list for medical imaging was not available to the taskforce. Work with a national clinical network is required to establish a shared view of waiting lists for all high-volume modalities by priority, ethnicity and waiting times

**Endoscopy:** There is no national collection of waiting list data, including ethnicity, for patients waiting for some procedures. National reporting of waiting times by priority bands only exist for people who have had their colonoscopy in a particular month. The Taskforce was unable to quantify the additional volume of endoscopy procedures required to achieve recovery

**First Specialist Assessment (FSA):** The number of people waiting longer than four months for FSA has increased over the period of the COVID-19 pandemic. In December 2019 12,894 patients (11% of the waiting list) were waiting more than four months, in June 2022 there were 18,274 more people on FSA waiting lists and the number of people waiting longer than four months has trebled to 35,264 patients (25% of the list). The number of people waiting longer than 12 months has increased 17-fold from 253 to 4,255 patients

The outpatient waiting list data available to the Taskforce did not include an ethnicity breakdown

**First Specialist Assessment and Follow up:** The number of follow ups delivered relative to the number of FSA delivered has increased in all regions

**Treatment – ESPI5:** Between March 2022 and June 2022 there was a 6% increase in the total number of patients waiting for treatment and a 7% increase in the number of patients waiting more than four months

In June 2022 there were 28,530 patients waiting more than four months (42% of the total waiting list).

To the end of June there were 5,555 patients waiting for treatment for more than 12 months, an increase of 1,832 over the three months. Just over half (n = 2,947) of all patients waiting more than 12 months are on Orthopaedic and General Surgery waiting lists

This increase in people waiting longer than 12 months has not been shared equitably. There has been a 53% increase in the number of Māori waiting more than 12 months compared to 49% for non-Māori, non-Pacific people

The current treatment waiting list contains (on average) 5.2 months' worth of work. If we wanted to reduce this so that we only had three months' worth of work on the waiting lists, we would need to provide approximately 30,000 additional procedures

There is insufficient workforce and capacity to carry out this work immediately. If it were feasible to purchase this work, it would cost approximately \$254M a sum that is increasing by about \$10M each month.

## Recommendations:

The Taskforce's 101 recommendations are grouped into 19 sections:

Equity	First specialist assessment
Planned care overview	Telehealth
Continuum	Treatment
Unmet need	Consistency in process
The "post-code lottery"	Follow-up
Clinical guidance	Private capacity
Terminology	Adoption of new technology
Primary care	Facilities
Endoscopy	Information frameworks
Radiology	

## Key highlights

Greater consistency is required by ensuring consistent clinical pathways and approaches to prioritisation of their care are used within all districts. This includes expanding the use of clinical pathways developed in some districts but not used universally around New Zealand

Access must be improved to diagnostic imaging for clinicians working in primary care. This will accelerate decision making meaning those people who need care that can only be provided by specialist services receive it sooner

We need to gain a complete understanding of the imaging capacity required to reduce waiting times

Services for Māori and Pacific via Māori or Pacific focused providers improve access and engagement with health services. These should be expanded and funded to be sustainable

More care should be provided in a primary care setting to release hospital and secondary specialist services capacity for work that only hospitals can do

Waiting list management must be consistent with high priority patients treated on time and lower priority cases treated in order of entry to the waiting list. This should ensure consistent approaches to equity in waiting times

Regional cooperation must be improved, especially to manage capacity

A long-term view needs to be taken to planning acute care capacity as this also protects planned care capacity

There is more work to do in determining the best use of prioritisation tools noting there is wide variation within regions and across the country

The Plan promotes the concept of "value to patients" by working towards reducing the number of unnecessary follow up outpatient appointments to release capacity to for first specialist assessments

Data collection, its sharing and use to inform demand and production planning needs improvement. Inconsistency and lack of standardisation makes it difficult to compare across hospital networks. It will also improve medium- and long-term planning to enable work to be outsourced sustainably to providers

Staffing capacity and workforce pipeline development are important enablers to improving Planned Care delivery

Improved contracting processes with third party providers are necessary to reduce duplication and optimise available capacity.