Security classification – In Confidence

Office of the Minister of Health

Cabinet Social Wellbeing Committee

Planned Care $282.5 Million COVID-19 backlog and waiting list initiative

Proposal

1 This paper seeks approval for how the additional $282.5 million funding made available in Budget 2020 to address the COVID-19 backlog and reduce Planned Care waiting lists impacted by the response to COVID-19 will be allocated.

Relation to government priorities

2 This proposal relates to the government's priority of improving physical and mental well-being by supporting timely access to Planned Care services to meet the demand on New Zealand health services and the principles of equity, access, quality, timeliness and experience.

Executive summary

3 District Health Boards (DHBs) are monitored on the number of patients waiting for treatment, assessment, follow up and scans with parameters set for maximum wait times. All DHBs have services below expectations, across a range of service types. In Budget 2020 we agreed to additional funding of $282.5 million over 3 years to enable DHBs to lift the levels of Planned Care delivery to address COVID-19 backlog and reduce waiting lists.

4 I am seeking agreement to the plan for allocating this funding. This initiative will not only enable services to be provided to those patients that had services deferred due to COVID-19, but can also enable a substantial improvement in DHB delivery models for Planned Care, reducing waiting lists for all patients.

5 I propose that the funding be used for initiatives in 2020/21, 2021/22 and 2022/23 across three phases:

- Phase One: Short Term – by 30 September 2020. This phase has already commenced with the Ministry of Health (the Ministry) engaging with DHBs to implement initial strategies;
- Phase Two: Medium Term – by June 2021; and
- Phase Three: Long Term – by June 2023.

6 DHBs have provided comprehensive Improvement Action Plans to the Ministry identifying strategies and actions to reduce COVID-19 backlogs and improve delivery of Planned Care services. DHBs are expected to create an environment of change and improvement and deliver a sustainable impact commencing with immediate effect and spanning over a three-year period.

7 Improvement Action Plans will be reviewed by 14 August 2020. Once they have been further developed and finalised realistic individual DHB and national trajectories to recovery will be confirmed.

Background

8 Planned Care is the description given to medical and surgical services that aren't required as an emergency or funded through the Accident Compensation Corporation (ACC). Planned Care generally begins from the point a person is referred by their primary care provider for specialised care. It excludes services such as Mental Health and Maternity.

9 While DHBs continued to deliver urgent non-deferrable services during the National Alert Level 4, many non-urgent services were deferred to limit the spread of COVID-19 and to enable DHBs to plan and prepare for treating affected patients.

10 As at 5 June 2020, the Ministry of Health estimates that there had been approximately 114,000 health appointments that have been cancelled or deferred as a result of the COVID-19 response.

11 There will also be an ongoing need for the continuation of infection control and some physical distancing requirements which will impact the return to normal levels of delivery in the short term.

12 The Ministry has modelled various scenarios for reductions in surgical inpatient waiting lists. It is currently estimated that patients waiting greater than four months (the current maximum expectation) will have grown from approximately 16,000 patients in April 2020 to over 28,000 by the end of June 2020. This is due to much restricted DHB activity in March and April 2020 and continuing capacity constraints during May and early June 2020. The estimates also account for a higher proportion of urgent work being undertaken than normal due to the reduced capacity.

Pre-Existing challenges for Planned Care

13 While volumes of Planned Care provided has increased, waiting time performance has deteriorated in the last several years.

14 Other issues impacting on timely delivery of services to patients include:

- growing demand for service – increased acute demand and complexity of presentations;
- capacity constraints – limited theatre, ward and Intensive Care Unit (ICU) capacity
- workforce availability – attracting and retaining clinicians, including surgeons is problematic in a range of services;
- industrial action – some professional workforce groups over the last few years have taken industrial action regarding employment conditions and pay, resulting in cancellations of Planned Care activity;

- service planning and management – DHBs have varying levels of sophistication in planning and delivering services; and
- deficit management – services that do not match capacity to the demand for the service leads to a backlog of long waiting patients.

Planned Care strategic approach

15 Changes were already underway in 2019/20 to the way Planned Care services were counted, funded and measured.

16 DHBs have been working on three-year plans to sustainably change the way Planned Care services are planned and delivered to:

- improve equity of access to, experience of, and outcomes of care;
- increase the volume, and expand the range of interventions provided to meet changing population health needs, priorities and preferences;
- implement changes to models of care where this would lead to an improvement in capacity;
- make better use of workforces such as allied health, technicians, nursing and primary care clinicians;
- remove unwarranted variation from the system, such as Did-Not-Attends, cancellations, unnecessary follow-ups;
- increase the provision of care in less resource-intensive settings and support non–surgical care alternatives; and
- increase the focus on prevention and early intervention programmes to improve wellbeing and reduce the need for more complex and expensive interventions.

Proposed approach to allocating funding

17 Given the work that was already underway to improve the delivery of Planned Care services, it is proposed that the additional $282.5 million funding boost for Planned Care is used primarily to address the backlog of waiting lists impacted by COVID-19 and those existing prior to March 2020.

18 Due to the scale and complexity of the issues faced by DHBs, this funding alone will not be sufficient to achieve a turnaround in DHB waiting list performance. There will need to be a comprehensive approach taken to optimising capacity, managing patient flows, implementing service improvements, improving equity, managing performance and engaging stakeholders.

19 The approach taken with this initiative will ensure:

- there is an immediate increase in delivery to halt the growth in waiting lists;
- DHBs make best use of the capacity in the health system including the private sector, community and primary care settings;
- longer term changes to models of care (workforce roles, delivery settings, prevention focus) will be implemented alongside the waiting list improvements;

- all levers, including funding, will be used to ensure delivery of this initiative;
- health equity is at the forefront of improvements and will be actively monitored; and
- within the three years of the initiative excessive waiting will be eliminated.

20 The core use of the additional $282.5 million funding will be to fund additional Planned Care services to address the COVID-19 waiting list backlog and those that were prior to March 2020 over the next 3 years. This will be allocated as $7.5 million for the provision of additional resources for monitoring of progress and implementation of initiatives, $212 million for additional delivery and improvements to delivery models, $3 million for Primary Care initiatives to undertake wait list assessments, $10 million for workforce initiatives and $50 million in the initial year for capital expenditure.

21 The use of this funding is expected to be applied by DHBs through additional clinics and theatre sessions in evenings or weekends, or through realignment of service provision in public hospitals.

22 There will also be an increase in the use of private providers in order to make the best use of all capacity that is available in the health system, particularly for hospital treatment and radiology. I expect DHBs and their local private hospital(s) to reach appropriate contractual agreements that allow for services to be increased to address backlogs.

23 The Ministry is facilitating discussions with the New Zealand Private Surgical Hospitals Association to ensure that a national approach is developed to access private capacity. There is also some intersection with the Accident Compensation Corporation (ACC) and their efforts to support increased volumes of treatment. Ongoing discussions are underway with ACC to identify the best model of working together and avoid competing for the same public or private capacity.

Performance management

24 At the end of June 2020, the Ministry requested DHBs provide comprehensive Improvement Action Plans identifying strategies and actions to reduce COVID-19 backlogs and improve delivery of Planned Care services. DHBs are expected to create an environment of change and improvement and deliver a sustainable impact over a three-year period.

25 These plans are currently being negotiated and agreed by the Ministry. Funding allocations to DHBs will be determined following analysis of the size of waiting lists and effectiveness of the proposed strategies, with quick wins and more sustainable longer-term plans.

26 Regular reporting and monitoring are already underway and will continue to ensure the Ministry has oversight of actual delivery against plan. In addition, DHB Performance Meetings are regularly held between the Ministry and

DHBs ensuring an oversight is maintained on various DHB aspects including Planned Care performance.

27 Given current and historical service performance, we need to act with a degree of pace and urgency. While this funding approach has not yet been agreed, I have asked the Ministry to fast-track delivery of the initial approach so we can see some immediate results in the early part of 2020/21 and this has already commenced with certain DHBs. I will ensure that this initiative is at the forefront of my discussions with Board Chairs and hold them accountable for progress.

Incentive funding

28 In order to ensure that this funding is used to support an overall increase in service delivery, payments will be made only for delivery of services over and above agreed 'normal' levels of delivery. A proportion of funding will also be 'at risk' based on achievement of defined standards of waiting list management.

29 A proportion of the funding will also be used to incentivise the achievement of milestones in the reduction of waiting lists. This approach was previously used successfully between 2013 and 2015 when the maximum waiting time for first specialist assessments and treatment was reduced from six months to four months.

Managing waitlists and patient flow

30 The number of people on Planned Care waiting lists that wait too long for services is dependent on a number of factors: the rate of new referrals accepted by a service; the rate of delivery or outflow from the service; the order in which patients are selected to receive the service; and the amount of unwarranted variation in the delivery of the service. Although an increase in delivery is critical to reducing waiting lists, on its own it may not be enough. The flow of patients through the service must also be well managed.

31 Through the use of Improvement Action Plans, setting of expectations, measurement and monitoring, the Ministry will ensure that DHBs follow good practice patient flow processes. Funding will also be made available to enable primary care review of patients that have been waiting beyond their clinically intended timeframe with a risk of deterioration.

Service improvement

32 Alongside an increase in the delivery of services to address the COVID-19 backlog waiting list, improvements need to be made to the way services are planned and delivered. This initiative will be closely linked to the DHB Performance Programme. In addition, further Planned Care key improvement areas have been identified.

33 The implementation of sustainable improvements will enable the gains made in managing waiting lists to be maintained beyond the three years of this initiative.

Workforce

34 Funding of $10 million will be targeted to support workforce initiatives that enable changes in delivery models, promote leadership, lift capability and address constraints in key areas. These initiatives will help mitigate the impact of a substantial increase in delivery on the existing health workforce.

Physical capacity

35 Availability of physical capacity (theatres, clinic rooms etc) is vital for the delivery of Planned Care. This initiative recognises the need to support increased physical capacity in innovative ways.

36 $50 million capital funding has been set aside for 2020/21 to commission a number of flexible options for additional capacity, this may include digital enablers.

Phasing of the initiative

37 I propose that the funding be used for initiatives in 2020/21, 2021/22 and 2022/23 across three phases.

- Phase One: Short Term – by 30 September 2020. This phase is already under way with DHBs focusing on an immediate reduction in the COVID-19 backlog and the growth of waiting lists, confirming capacity across public and private sectors, completing agreement of all DHB action plans, reviewing inequity, determining gender implications, establishing the programme approach and setting expectations and milestones.
- Phase Two: Medium Term – by June 2021. Monitoring of progress in reducing waiting lists, national co-ordination of capacity improvements, implementation of DHB-led improvements, addressing equity gaps and gender implications nationally with targeted approaches, advancing DHB-led initiatives that generate measurable and sustainable efficiency gains and spreading successful innovations between DHBs nationwide
- Phase Three: Long Term – by June 2023**.** Focus on fully implementing and sustaining DHB local and regional plans as well as longer-term sustainable changes to lift capacity.

Recovery modelling

38 Trajectories to recovery vary according to the relationship between inflows, outflows and order of service. Conclusions from this modelling show that providing an excess of outflows over inflows is the key to recovery, but this will be very challenging in the short term. It will require the introduction of additional capacity as early as possible in 2020/21.

39 There are concerns about the achievability of a rapid increase in capacity, particularly if alert levels escalate again. However, as the Ministry reviews the initial Improvement Action Plans, it has been noted that DHBs have commenced several strategies to reduce waiting lists, and have presented initial plans around how they can utilise a portion of the $282.5m in the first year.

40 All Improvement Action Plans will be reviewed by 14 August 2020. Once they have been refined realistic individual and national trajectories to recovery will be confirmed. DHBs that have increased waiting lists as a result of COVID-19 are indicating short trajectories to recovery, and plans submitted indicate recovery times of approximately 6 months. DHBs with COVID-19 and historical, longer term issues are at this stage predicting longer timeframes. Further discussions regarding strategies for these DHBs will aim to minimise trajectories to recovery, although initially some trajectories are out to 24 months before recovery is achieved. The Ministry is working with all DHBs to ensure trajectories are realistic and achievable, but the expectation is that care must be provided in the fastest time possible.

Sector engagement to date

41 A Sector Advisory Group has been established to identify and consider sustainable approaches to eliminate wait lists.

42 The Ministry directed DHBs to make best use of capacity in the health system and increase Planned Care as the national alert levels lowered.

43 DHBs have been required to confirm capacity across public and private sectors and to commence discussions with private providers.

44 DHB Chief Executives, Chief Operating Officers and General Managers Planning and Funding have been engaged with regularly during the COVID-19 pandemic and in particular about an increase in Planned Care once the alert levels began to lower.

45 Engagement with the health sector has been undertaken with the clinical colleges and associations to gain their support and input into the initiative.

Initiative progress to date

46 Resourcing plans have been developed for departmental expenses to provide additional resource and expertise. DHBs are being provided weekly dashboards on their management of waiting lists and increasing delivery of Planned Care. This will enable monitoring of DHB progress and implementation of national initiatives. Individual DHB and national figures will be reported to me.

47 The Ministry has specified the requirements for Improvement Action Plans that DHBs are submitting for all their non-compliant services, including Computerised Tomography (CT) scans, Magnetic Resonance Imaging (MRI)

and ultrasound scans, First Specialist Assessments, Follow Up appointments and treatment, all of which are components of Planned Care.

48 For each non-compliant service, the plans contain:

- strategies and actions for recovery;
- context and possible constraints to success;
- details of how the plan will be implemented over the time frame to recovery;
- management of clinical risk and patient experience;
- improvement of and assurance of equity;
- expected trajectories to recovery for each service;
- milestones expected to be achieved with dates; and,
- tools and resources that the Ministry may be able to provide to assist with waiting list reduction.

49 The Ministry has developed an initial strategy for radiology services and agreed with DHBs to deliver an additional 4,193 CT or MRI scans in June and July 2020. Further delivery and service improvements will be supported once Improvement Action Plans are agreed.

50 There is clear evidence from conversations held with DHBs that there is an appetite to regain compliance and improve patient access, equity and experience. Conversations to date with DHBs as plans are being developed have been constructive with a commitment to achieving success.

National strategies

51 In addition to an increase in delivery of services, improvements need to be made to how services are planned and delivered if reduced waiting lists are to be maintained. The Waiting List Initiative will be closely linked to the DHB Performance Programme, the use of the DHB Sustainability Funding and each DHB's Planned Care three-year plan.

52 Through the Improvement Action Plans and discussions with DHBs the Ministry is identifying whether there are any "pinch points" for specific services. By recognising and developing solutions it will be possible to roll solutions out nationally rather than in isolated pockets. Cohorting of DHBs with like issues will facilitate a wider approach to solutions and prevent siloing which has impacted DHB's ability to determine solutions that are regional or cross regional.

53 For Planned Care, the Ministry has identified the following key improvement areas:

- production planning;
- clinical prioritisation;
- enhancing the primary – secondary interface;
- improving the use of the multi-disciplinary health workforce within hospitals and the community;

- relationship with the private sector;
- the Choose Wisely initiative;
- an increased focus on prevention, well-being and early intervention activities; and
- improvements across DHB regional pathways and regional capacity planning.

Health equity gains

54 Māori and Pacific communities can experience disproportionate barriers to access for treatment and care. When services are under pressure due to large waiting lists, health inequities can become even more pronounced unless they are specifically managed.

55 Inequality needs to be addressed through targeting the equity gap. To do this DHBs will need to understand, by service, the inequalities present within their wait lists.

56 This initiative provides funding to deliver additional services and reduce waiting lists which will relieve some of these constraints. Policy parameters around access to additional funding will also ensure that robust clinical prioritisation processes are used, which help to reduce unwarranted variability in decision making about access to care and the urgency of that access.

57 Prioritisation Tools for Planned Care will be reviewed and if necessary, a modification made to support reducing inequity.

58 This initiative will improve health equity through various methods:

- scoping to understand the demographics of the patient wait lists through Phase 1;
- integration of ethnicity as a standard variable across data sets, to support the tracking, monitoring and reporting of ethnic health disparities (particularly for Māori and Pacific population groups);
- the newly established Planned Care equity working group will develop and advise on equity initiatives and on the causative factors and potential solutions across the Planned Care pathways;
- practical, evidence-based strategies to address common equity problems will be disseminated by the Ministry;
- DHBs have already been advised to identify vulnerable Maori and Pacific cohorts and ensure appropriate resources are provided to ensure they can access services (e.g. transport, care coordination);
- determine DHB equity targets/expectations for integration into DHB planning and accountability rounds for the ensuing financial year; and,
- monitoring of reductions in inequity based on DHB equity targets and expectations.

Anticipated benefits

59 This initiative will provide funding and support for District Health Boards to deliver additional Planned Care Interventions, outpatient assessments and radiology imaging to enable a reduction in waiting lists. This is an expansion of an existing initiative (Increasing Planned Care Interventions) to include funding of additional service types and volumes.

60 This initiative reduces the risk of avoidable harm occurring to patients if they wait beyond expected clinical timeframes for their assessment or treatment. It also will contribute to the continued delivery of public services that enable people to access Planned Care before they suffer unreasonable distress or harm.

61 I am seeking both short-term care for those impacted by COVID-19 and long term, sustainable improvements through this initiative. If the activities are delivered as planned, I would expect to see a step change in the way District Health Boards plan and deliver services and enable excessive waiting to be eliminated.

Next steps

62 I am engaging with DHB Chairs regularly about the importance of this initiative and discussing their progress with them.

63 This initiative will support sustainable service improvement, and the Ministry will oversee the DHBs' changes to delivery models and reduction in waiting lists over the duration of the initiative.

64 I propose that I report back to Cabinet on the progress of this initiative in approximately six months.

Consultation

65 The Treasury, the Department of the Prime Minister and Cabinet (Policy Advisory Group) and the Ministry of Health Maori Health Directorate have been consulted on this paper.

Financial implications

66 The recommended funding allocation of $282.5 million over 3 years will be allocated as follows:

	$ million			
	2020/21	2021/22	2022/23	Total
Departmental Output Expenses • Provision of additional resource and key expertise to enable monitoring of DHB progress and implement national initiatives	1.5	3.0	3.0	7.5
Non-Departmental Output Expenses • Funding additional delivery and improvements[1] • Funding of primary care to undertake waiting list risk assessments • Workforce initiatives	80.0 1.0 4.0	66.0 1.0 3.0	66.0 1.0 3.0	212.0 3.0 10.0
Non-Departmental Capital Expenditure • Commissioning additional operating theatre and clinic spaces	50.0			50.0
Total	**136.5**	**73.0**	**73.0**	**282.5**

67 I propose that future decisions about how this funding is spent be delegated to the Minister of Health.

Legislative implications

68 There are no legislative implications.

Impact analysis

69 Based on the information provided, the Regulatory Quality Team at The Treasury has determined that a Regulatory Impact Analysis is not required for this proposal as it has no or only minor impacts on businesses, individuals or not-for-profit entities.

Gender implications

70 Analysis of gender bias in waiting list data lists will provide a better understanding of implications and indicate the benefits and improvements that can be made moving forward.

[1] It should also be noted that there is an in-principle transfer of Planned Care 2019/20 funding of approximately $20 million that will also be used to support additional delivery and service improvements during 2020/21.

Disability perspective

71 Consistent with commitments and expectations in the New Zealand Disability Strategy (2016-2026) and the Disability Action Plan (2019-2023) it is intended that data is collected on disabled people's access to the backlog and waiting list services for the purpose of understanding whether equitable access to services is being achieved. There is the opportunity to initiate work with disabled people to consider how Planned Care can be enhanced for disabled people to respond to the findings of previous research by the Ministry which indicated that more could be done to achieve better outcomes from medical interventions for people with intellectual impairments.

Publicity

72 This is a matter of substantial public interest and the timeliness of access to Planned Care has a direct impact on New Zealander's confidence in the publicly funded health system.

73 I intend to provide regular updates to the public on the progress of this important initiative.

Proactive release

74 I do not propose to proactively release this paper.

Communications

75 I will announce the proposal with the dissemination, monitoring and reporting of the initiative undertaken by the Ministry of Health.

Recommendations

The Minister for Health recommends that the Committee:

1 **Note** that in May 2020, Cabinet:

1.1 Agreed to provide $282.5 million over 3 years for initiatives to improve the wait list performance of DHBs [CAB-20-MIN-0219.12 refers]

1.2 Agreed that the Minister of Health will report back to Cabinet before 30 June 2020 with a plan for delivering these additional Planned Care surgeries with a focus on reducing inequities [CAB-20-MIN-0219.12 refers]

2 **Note** that the waiting list performance of DHBs is variable and has deteriorated in recent years with DHBs facing increasing capacity, workforce and financial pressure due to demographic change, rising burden of disease, increased clinical complexity and technological change, as well as other ongoing cost and labour cost pressure.

3 **Note** that DHBs have submitted Improvement Action Plans to the Ministry. These will be reviewed and further developed to ensure an environment of

change and improvement, and the delivery of sustainable impact over a three-year period.

4 **Note** that once the plans have been finalised realistic individual DHB and national trajectories to recovery will be confirmed.

5 **Approve** the allocation of the funding as follows:

	$ million			
	2020/21	2021/22	2022/23	Total
Departmental Output Expenses • Provision of additional resource and key expertise to enable monitor DHB progress and implement national initiatives	1.5	3.0	3.0	7.5
Non-Departmental Output Expenses • Funding additional delivery and improvements • Funding of primary care to undertake waiting list risk assessments • Workforce initiatives	80.0 1.0 4.0	66.0 1.0 3.0	66.0 1.0 3.0	212.0 3.0 10.0
Non-Departmental Capital Expenditure • Commissioning additional operating theatre and clinic spaces	50.0			50.0
Total	**136.5**	**73.0**	**73.0**	**282.5**

6 **Note** that the Minister of Health is engaging regularly on the topic of DHB performance and has asked the Ministry of Health to develop further detail to support improved wait list performance of DHBs in the short, medium and long term

7 **Note** that Ministry of Health officials are available to provide regular updates to Ministers at the Cabinet Priorities Committee

8 **Invite** the Minister of Health to report back to Cabinet on the progress made in implementing the Planned Care COVID-19 backlog and waiting list initiative every six months.

Authorised for lodgement

Hon Chris Hipkins

Minister of Health