Delivering scheduled services to patients

Progress in responding to the Auditor-General's recommendation

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Introduction

1.1 In June 2011, we published our report on the progress that the Ministry of Health (the Ministry) and district health boards (DHBs) had made towards achieving the objectives of a strategy released in 2000 – *Reduced Waiting Times for Public Hospital Elective Services: Government Strategy* (the Strategy).

1.2 Elective services are non-urgent medical and surgical services (specialist advice or a form of treatment, or both). In this progress report (and in our 2011 report), we call these scheduled services. This is partly because the lack of urgency means that the services are scheduled ahead of time and partly because the term "elective" suggests that there is a degree of choice that the patient might not agree they have.

Our previous findings and recommendation

1.3 Despite the improvements that DHBs had made in the 10 years before we published our June 2011 report, we found that New Zealand did not yet have a nationally consistent and equitable system for scheduled services.

1.4 We recommended that the Ministry and DHBs agree on:

- what they would do to improve their progress in more fully achieving the Strategy's objectives; and
- when they would improve their progress and how they would demonstrate that improvements had been achieved.

1.5 The priority areas that we recommended they focus on were ensuring that:

- patients are more consistently selected for first specialist assessments;
- patients are more consistently prioritised for treatment;
- a greater proportion of patients receive scheduled services within the expected time limits;
- a greater proportion of patients are treated in priority order; and
- progress is made in quantifying the level of unmet need for scheduled services.

1.6 We encouraged the Ministry, DHBs, and medical specialists to identify any disincentives to further progress. We also encouraged them to focus on putting in place systems and tools to ensure that patients with the greatest need have access to services at the right time.

The response to our findings and recommendation

1.7 The Ministry supported our recommendation and it has since provided us with regular reports on its plans to further improve the scheduled services system.

1.8 In December 2013, we published a report of our assessment of the Ministry's progress.[1] This report is our second and final progress report, which should be read alongside our 2013 progress report.

1.9 In this report, we focus on the Ministry's work with the DHBs. We have not audited each DHB's individual work programme on scheduled services.

1.10 Overall, we are satisfied with the progress made. Although some patients have waited longer than the assigned time frames for services, the number of people is within the small "buffers" allowed.[2] Progress continues to be made in preparing and implementing tools to prioritise patients for treatment, which should lead to greater consistency in getting access to services throughout the country. From 2011 to 2015, more people per 10,000 population had access to scheduled surgery and the gap between the DHBs with the highest and lowest standardised intervention rates narrowed.

The Ministry's current approach

1.11 The Ministry's and DHBs' work programme for scheduled services is focused on:

- reducing waiting times for first specialist assessment and treatment;
- delivering more scheduled surgical treatment;
- improving consistency in selecting patients and prioritising them for treatment, which includes treating cardiac surgery patients in priority order; and
- measuring end-to-end pathways (National Patient Flow).

1.12 We discuss each of these aspects in turn, and update our December 2013 comments on unmet need.

Providing services within expected time limits

1.13 In February 2012, the Ministry introduced a plan stating that all patients waiting for a scheduled first specialist assessment or treatment should wait no longer than:

- six months from 1 July 2012;
- five months from 1 July 2013; and
- four months from 1 January 2015.

1 Controller and Auditor-General (December 2013), *Delivering scheduled services to patients: Progress in responding to the Auditor-General's recommendations*, www.oag.govt.nz. The article is also included in *Public entities' progress in implementing the Auditor-General's recommendations 2014* (July 2014).

2 DHBs are allowed to have up to 0.4% of patients waiting longer for their first specialist assessment and up to 1% waiting longer for treatment.

1.14 Our main interest is in the number of patients who wait longer than six months for services, because that was the requirement when we did our audit in 2010 and 2011. However, because the requirements have changed, Figure 1 shows the number of patients who had waited longer than six months for services and – from January 2015 – the number of patients who had waited longer than four months for services. It shows that DHBs have not yet been able to consistently ensure that all patients get services within four or six months.

Figure 1
Number of patients waiting after six months and four months for scheduled services, June 2013 to September 2015

As at the end of:	First specialist assessment		Treatment	
	Patients waiting after six months	Patients waiting after four months	Patients waiting after six months	Patients waiting after four months
June 2013	9	N/A	34	N/A
June 2014	45	N/A	53	N/A
December 2014	1	N/A	29	N/A
January 2015	0	552	45	606
February 2015	2	650	43	620
March 2015	8	262	29	338
April 2015	4	261	28	266
May 2015	5	189	25	227
June 2015	21	171	23	196
July 2015	13	248	31	368
August 2015	8	117	41	357
September 2015	10	160	26	257

Source: Ministry of Health.

Notes: Data for the number of patients waiting after four months for services includes all patients who have been waiting longer than they should. Data was extracted from the National Booking Reporting System on 2 November 2015. The database is constantly changing, which means that the data might differ from data that the Ministry has published previously.

1.15 However, the percentage of patients waiting longer than expected is within the allowed buffers. At the end of September 2015:

- 99.99% of patients had received their first specialist assessment within six months;

- 99.93% of patients had been treated within six months;
- 99.82% of patients had received their first specialist assessment within four months; and
- 99.31% of patients and been treated within four months.

1.16 The Ministry told us that the patients who wait more than six months tend to be those who have delayed their treatment because of changes in their personal circumstances or because they are temporarily medically unfit when their treatment is booked.

1.17 Less often, the delay can be because of problems with the availability of people and resources at the DHB. When this happens, the Ministry expects that patients are kept informed about when their treatment will be provided.

Delivering more scheduled surgical treatment

1.18 As well as meeting shorter waiting times for a first specialist assessment and treatment, DHBs were to increase the number of scheduled operations they deliver by at least 4000 a year. They exceeded this number in all years from 2008/09 to 2014/15.

Selecting patients for a first specialist assessment more consistently and prioritising them for treatment

1.19 The Ministry is leading a programme to ensure that prioritisation tools for treatment are up to date. The programme introduces new nationwide tools for specialties that have not had them before. It has prioritised introducing new tools for high-volume surgical services. Figure 2 summarises progress since 2011 in introducing or revising selected prioritisation tools.

Figure 2
Summary of actions taken since 2011 in introducing or revising selected prioritisation tools

❑ 2013 update ❍ 2015 update

Treatment prioritisation tools	Preparation*	Trial	Implementation	Planned review date
Bariatric surgery	❑	❑	❑ ❍	2017
Cardiac surgery: urgency		❑	❍	2017
Cardiac surgery: appropriateness	❑ ❍			
Cataract			❍	2016
Ear, nose, and throat		❑	❍	2017

Treatment prioritisation tools	Preparation*	Trial	Implementation	Planned review date
First specialist assessments	❍	❍		
General surgery	❑	❍		2018
Gynaecology: general		❑	❍	2016
Gynaecology: sterilisation		❑	❑ ❍	2017
Orthopaedic – all adult surgery†	❑		❍	2018
Ophthalmology – all eye surgery††	❑ ❍	❍		2018
Plastic surgery: body deformity and skin lesion tools		❑ version 1 ❍ version 2		2015

Source: Ministry of Health.

Note: The Ministry plans to start work on prioritisation tools for urology surgery and vascular surgery in 2016.

* Preparation of a new tool or the first stage of revising an existing national tool.

† This tool replaces two earlier tools.

†† The completed cataract tool will be part of the whole-of-ophthalmology tool.

1.20 Since 2013, all new and revised tools have been hosted on a web-based National Prioritisation Interface. This means that patients are assessed electronically. The National Prioritisation Interface produces real-time reporting that allows each clinician to review all of their patients' assessments, and higher-level reporting for clinical directors to see results for a specific hospital department for clinical audits.

1.21 The Ministry and the clinical leaders for each tool[3] continue to work with DHBs to increase the adoption and use of all the tools. To encourage adoption and use, the Ministry is:

- visiting DHB clinical specialty meetings to discuss the tools and implementation process with clinicians;
- sending updates on progress to regional project managers;
- meeting clinical directors to introduce the new tools;
- having members of the working groups that prepare the prioritisation tools give presentations on the tools at national clinical meetings of the doctors' colleges or associations;
- encouraging clinicians to publish reviews of clinical prioritisation systems; and
- formally linking the new prioritisation tools to scheduled services patient flow indicators.

3 Each Prioritisation Working Group nominates clinical leaders, who are usually working as specialists in a DHB.

Treating more patients in priority order

1.22 Five DHBs do cardiac operations. In our 2011 report, we noted that there had been longstanding problems with ensuring that cardiac surgery patients were treated in a timely way. The New Zealand Cardiac Network[4] was pleased with the progress achieved by 2012/13 and considered that it provided a baseline on which to assess further improvements.

1.23 Figure 3 shows that the number of patients who were prioritised using the cardiac prioritisation tool (and who later received cardiac surgery) increased by about 68% between 2012/13 and 2014/15. Most DHBs increased the percentage of patients treated within the assigned time frames. The total percentage of patients treated within the assigned time frames increased from 75% to 79%.

Figure 3
Number and proportion of cardiac surgery patients who were prioritised and treated within assigned time frames, by selected district health boards, 2012/13 and 2014/15

District health board	2012/13			2014/15		
	Prioritised and treated within assigned time frame	Total prioritised and treated	Treated within assigned time frame	Prioritised and treated within assigned time frame	Total prioritised and treated	Treated within assigned time frame
Auckland	338	465	73%	507	657	77%
Waikato	117	171	68%	293	378	78%
Capital and Coast	245	300	82%	374	477	78%
Canterbury	57	75	76%	136	159	86%
Southern	29	38	76%	74	90	82%
Total	**786**	**1049**	**75%**	**1384**	**1761**	**79%**

Source: Ministry of Health.
Note: The Ministry collated this data from three sources. For various reasons, this means that the number of patients who waited longer than the assigned time frames is likely to be slightly overstated. The Ministry is working with DHBs to improve the completeness of data sent to the National Booking Reporting System, which is the preferred single source of data about waiting times.

4 The New Zealand Cardiac Network groups the National Cardiac Surgery Clinical Network, the four regional cardiac networks, the Cardiac Society of Australia and New Zealand, the Heart Foundation, primary health care, and the Ministry of Health. It oversees and co-ordinates a work programme that focuses on the entire cardiac care pathway to ensure that people have access to the care they need.

1.24 Figure 4 shows the number of patients who waited longer than 120 days for cardiac surgery. The total number decreased from 45 patients in 2012/13 to 38 patients in 2014/15. The number of patients who waited longer than 150 days was reduced from 12 patients in 2012/13 to two patients in 2014/15.

Figure 4
Number of cardiac surgery patients who waited more than 120, 150, and 180 days, by selected district health boards, 2012/13 and 2014/15

District health board	2012/13			2014/15		
	More than 120 days	More than 150 days	More than 180 days	More than 120 days	More than 150 days	More than 180 days
Auckland	13	3	1	3	0	0
Waikato	18	7	2	8	1	1
Capital & Coast	11	1	0	20	0	0
Canterbury	0	0	0	3	0	0
Southern	3	1	0	4	1	0
Total	**45**	**12**	**3**	**38**	**2**	**1**

Source: Ministry of Health.

Notes: The counts are cumulative. This means that patients who waited more than 180 days are included in all three groups. The Ministry collated this data from three sources. For various reasons, this means that the number of patients who waited longer than the assigned time frames is likely to be slightly overstated. The Ministry is working with DHBs to improve the completeness of data sent to the National Booking Reporting System, which is the preferred single source of data about waiting times.

1.25 Figure 5 shows the total number and percentage of patients who were treated in priority order for each time frame. It shows that the percentage of patients treated within 72 hours, 10 days, and 30 days increased. The percentage of patients treated before or on 120 days remained at 95%.

Figure 5
Total number and percentage of cardiac surgery patients treated within the assigned urgency, 2012/13 and 2014/15

All five DHBs	2012/13			2014/15		
	Patients treated within assigned time frame	Total number treated	Treated within assigned time frame	Patients treated within assigned time frame	Total number treated	Treated within assigned time frame
< 72 hours	30	53	57%	182	278	65%
< 10 days	44	82	54%	162	226	72%
< 30 days	191	364	52%	343	526	65%
≤ 120 days	521	550	95%	697	731	95%
Total	**786**	**1049**	**75%**	**1384**	**1761**	**79%**

Source: Ministry of Health.
Note: The Ministry collated this data from three sources. For various reasons, this means that the number of patients who waited longer than the assigned time frames is likely to be slightly overstated. The Ministry is working with DHBs to improve the completeness of data sent to the National Booking Reporting System, which is the preferred single source of data about waiting times.

1.26 The five DHBs report to the Ministry every four weeks. This can increase to weekly reporting if progress does not meet expectations, and includes regular teleconferences between Ministry and DHB staff to discuss plans for ensuring that patients are treated appropriately. Options could include increasing capacity, improving operational processes, and transferring patients to another DHB for treatment.

1.27 The National Cardiac Surgery Clinical Network has agreed with the Ministry to reduce the maximum waiting time for cardiac surgery to 90 days from 120 days.

1.28 We consider that the DHBs have made good progress and it is encouraging that they plan to further shorten the maximum waiting time for treatment.

Measuring the patient pathway from start to end

1.29 National Patient Flow, the new national data collection, will eventually allow patients to be followed from referral to scheduled services to the outcome of the referral, between services within a DHB, and between DHBs. It is expected to provide comprehensive information that will allow an understanding of patient pathways at an individual, DHB, and national level. This includes collecting data on patients who were referred to DHBs but not given a scheduled first specialist assessment and/or treatment and the reasons why.

1.30 The project has three phases:

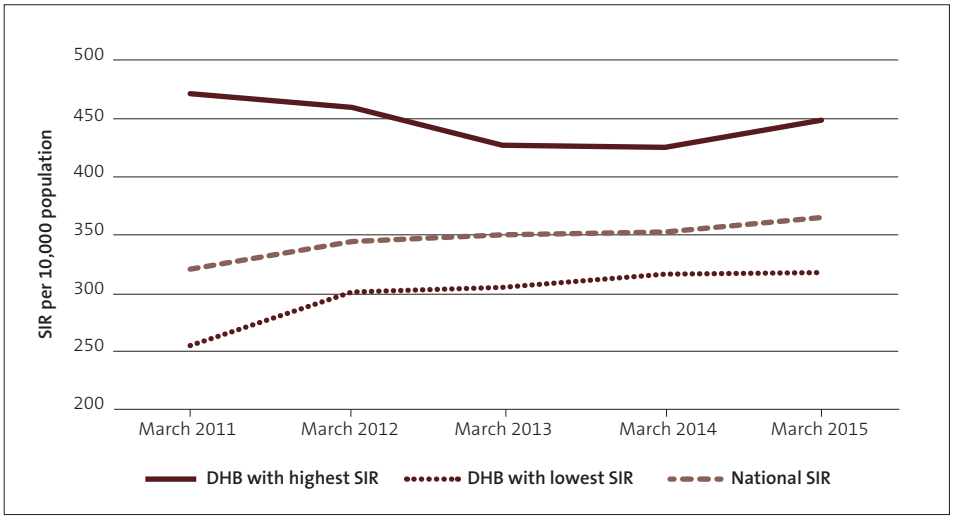
- In July 2014, DHBs started collecting information on referrals for first specialist assessments. The Ministry told us that all DHBs have substantive quantities of data in the National Patient Flow for 2014/15.
- From 1 October 2015, DHBs started to include information on referrals for scheduled surgery and some other procedures, such as colonoscopy.
- From July 2016, DHBs will start entering more data, including a wide range of treatment and diagnostic services. This will allow related referrals to be linked and reasons for referral to be given a clinical classification.

Quantifying unmet need

1.31 In our 2013 report, we described the different methods available to the Ministry to quantify the unmet need for scheduled services and the progress that had been made in reducing that unmet need. In the following paragraphs, we update some of the data.

1.32 At a high level, equity of access[5] can be assessed by comparing DHBs' treatment rates, or standardised intervention rate (SIR). The aim is that each DHB will deliver an amount of scheduled services equivalent to its share of the population. Figure 6 shows trends since March 2011. It shows that the national intervention rate increased to 365 per 10,000 population, and the gap between the DHBs with the highest and lowest SIRs has decreased from 215 in 2011 to 131 in 2015.

Figure 6
Standardised intervention rates for all surgery, 2010/11 to 2014/15



Source: Ministry of Health. Data is for the year ending 31 March.

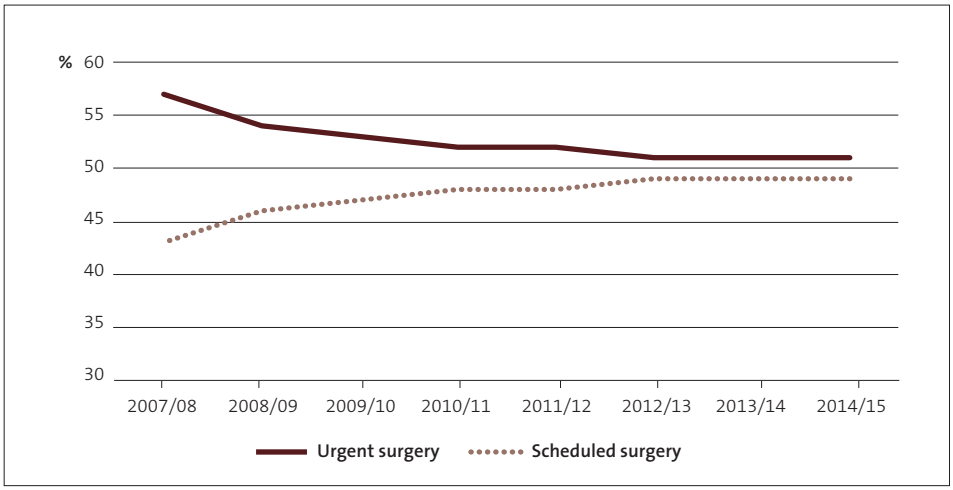
5 Equity of access means that patients with a similar level of need and ability to benefit from treatment will have similar access to scheduled services, regardless of where they live.

1.33 In our 2013 report, we discussed that some decrease in the demand for urgent treatment can be expected:

- when fewer patients who are scheduled for services are treated urgently;
- when doctors assessing inpatients use scheduled services prioritisation tools to decide whether those patients have higher priority than patients who have already been booked for treatment; and
- when general practitioners are confident that referrals to scheduled services will be handled in a timely way.

1.34 We reported that the percentage of patients receiving urgent surgical treatment decreased from 57% in 2007/08 to 51% in 2012/13. In our 2013 report, we said that this indicated that the system for delivering scheduled services had become more effective and efficient over time. Figure 7 shows that the percentage of patients treated urgently has been steady at 51% since 2012/13.

Figure 7
Percentage of patients receiving urgent and scheduled surgery, 2007/08 to 2014/15



Source: Ministry of Health.
Notes: Data is for all surgical purchase units (including skin lesions and intra-ocular injections used to treat conditions such as age-related macular degeneration). Data was extracted from the National Booking Reporting System on 11 August 2015. The database is constantly changing, which means that the data might differ from data that the Ministry has published previously.